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"You Needed to Accept the Situation": Resilience of Nursing Home Residents in Times of COVID-19

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Article

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Résumé

Les mesures restrictives prises par les maisons de soins infirmiers au cours de l'épidémie de COVID-19 en 2020 (p. ex., la quarantaine) peuvent avoir été des facteurs de stress importants face auxquels les résidents ont eu besoin de résilience pour préserver leur bien-être. Basée sur 30 entretiens semi-structurés avec des résidents de maisons de soins infirmiers et des proches, cette étude a exploré les expériences vécues en ce qui concerne les mesures restrictives. Les données ont été recueillies dans des services psychogériatriques, somatiques et mixtes aux Pays-Bas et en Flandre (Belgique). Les mesures restrictives ont été des facteurs de stress importants pour les résidents, comme en témoignent les sentiments de solitude, de tristesse et d'impuissance. Pour faire face à ces mesures, les résidents ont utilisé diverses ressources déterminées par des facteurs individuels (p. ex., la santé), interactionnels (p. ex., les possibilités d'interactions sociales) et contextuels (p. ex., les politiques de l'établissement). Puisque les expériences vécues face aux mesures restrictives semblent être liées à la résilience des résidents, il est crucial de renforcer les ressources sur les plans individuel, interactionnel et contextuel.

Abstract

The restrictive measures taken by nursing homes during the COVID-19 outbreak in 2020 (e.g., quarantine) may have been important stressors for which residents needed resilience to safeguard their well-being. Based on 30 semi-structured interviews with nursing home residents and close relatives, this study explored the lived experiences with respect to the restrictive measures. The data were collected in psychogeriatric, somatic, and mixed wards in The Netherlands and Flanders, Belgium. The restrictive measures were important stressors for residents, indicated by feelings of loneliness, sadness, and powerlessness. To deal with these measures, residents used various resources, which were determined by factors in the individual (e.g., health), interactional (e.g., possibilities for social interactions) and contextual (e.g. nursing home policy) domains. Because the lived experiences with respect to the restrictive measures seemed to relate to the resilience of nursing home residents, it is crucial to reinforce resources in the individual, interactional, and contextual domains.

Background

Restrictive Measures to Deal with the COVID-19 Outbreak in Nursing Homes

During the COVID-19 outbreak at the beginning of 2020, nursing home residents worldwide were seriously threatened by the virus (Hsu et al., 2020; Kadowaki & Wister, 2022; Ouslander & Grabowski, 2020). In Flanders and Brussels, approximately 9,000 of the 82,000 residents died in the period March–April 2020, which was an excess mortality of 3,117 residents (or a rise of 53%) compared with the same period in 2019 (Flemish Agency for Care and Health, 2020). Nursing home residents were disproportionately affected by COVID-19 because of their greater likelihood of co-morbidity (Jordan, Adab, & Cheng, 2020; Logar, 2020; Wister & Speechley, 2020) and because of organizational factors (Huang et al., 2020), such as the large number of people living closely together in those institutions. These factors as well as a lack of protective equipment and difficulty of achieving the complete isolation of certain residents (e.g., persons with dementia) made it difficult to control the spread of the virus (Schols, Poot, Nieuwenhuizen, & Achterberg, 2020).

In The Netherlands and Flanders, the national governments imposed various restrictive measures on nursing homes during the first months of the outbreak, with the aim of minimizing infections and deaths (Verbeek et al., 2020). Visitors were not allowed to visit between March 20 and May 24 2020 in The Netherlands, and between March 14 and May 17 2020 in Flanders. In

most nursing homes, residents were no longer allowed to leave the premises, and some nursing homes obliged their residents to remain in their own rooms for a number of weeks. Other restrictive measures were face mask ordinances, hygiene protocols, distancing measures, closing communal areas, prohibition of group activities, and isolation measures in cases of contamination.

The Impact of the Restrictive Measures on the Well-Being of Residents

The restrictive measures had a negative impact on the well-being of residents. Multiple studies reported increased levels of loneliness, depression, anxiety, and behavioural problems (Kaelen et al., 2021; Médecins Sans Frontières, 2020; Noten et al., 2022; Van der Roest et al., 2020). However, the overall impact of the restrictive measures varied between residents (Kaelen et al., 2021, pp. 10). A study by Paananen, Rannikko, Harju, and Pirhonen (2021) showed that although the perceived impact of distancing measures on residents and their family members was 91 per cent negative, 9 per cent was positive. In this respect, Chen (2020) stated that older persons with more resilience had better outcomes with regard to physical, cognitive and mental health, and successful ageing during the COVID-19 pandemic.

Resilience: Dealing with Restrictive Measures

Literature on resilience indicates that nursing home residents need a certain amount of resilience to be able to positively deal with burdensome situations (Chen, 2020). Resilience is defined as "a dynamic process encompassing positive adaptation within the context of significant adversity" (Luthar, Cicchetti, & Becker, 2000, p. 543). It refers to the ability to maintain a stable and good way of (physical, psychological, and social) functioning during difficult circumstances, by using resources that buffer the negative impacts of events such as the restrictive measures discussed here (Clark, Burbank, Greene, & Riebe, 2011; De Witte & Van Regenmortel, 2019; Janssen, 2013; Wister, 2022). Janssen, Van Regenmortel, and Abma (2011) make the distinction between resources in the individual, interactional and contextual domains. The individual domain refers to "the qualities within older people" (Janssen et al., 2011, p. 145) and includes resources such as acceptance, a feeling of control and mastery (Chen, 2020), and lifestyle behaviours that foster healthy aging (Wister, 2022). The interactional domain refers to "the way older people cooperate and interact with others to achieve their personal goals" (Janssen et al., 2011, p. 145) and includes resources such as empowering relationships with relatives. Social relations are crucial for resilience through the provision of information and instrumental support (Furlotte & Schwartz, 2017; Holston & Callen, 2021; Wilson, Plouffe, & Saklofske, 2021), encouraging coping behaviours, and enhancing self-esteem (Chen, 2020). The contextual domain includes factors on a broader political-societal level that relate to resilience (Janssen et al., 2011), such as organizational resources (e.g., available time of staff members, communication and information policy of nursing homes) (Pendergrast, Belza, Bostrom, & Errett, 2021). The framework by Janssen et al. (2011) also stresses the importance of taking into account the possible interaction among sources of strength in the three domains; for example, a feeling of mastery (individual domain) can enhance the bond with relatives (interactional domain) and stimulate residents to participate to resident meetings (contextual domain). Inversely, going to resident meetings can enhance the bond with other residents and strengthen a feeling of mastery. Further, because resilience processes always take place in a given socio-economic, cultural, and historical context, it is crucial to take the specific context into account when studying resources that give rise to resilience (e.g., nursing homes during the COVID-19 pandemic) (Siriwardhana, Ali, Roberts, & Stewart, 2014; Slater et al., 2021; Wilson, Walker, & Saklofske, 2021).

As Janssen et al. (2011) developed their theoretical framework of resilience with regard to community-dwelling older persons, it remains uncertain to what extent this framework also applies to persons in other contexts, such as in nursing homes. The specific nursing home context is relevant because research indicates that certain aspects of life in nursing homes (e.g., feelings of alienation) negatively influence the resilience of residents (Newman, Goulding, Davenport, & Windle, 2019). Research on resilience in nursing homes during the COVID-19 pandemic reported that certain factors may strengthen resilience in residents, such as the Internet and mobile technology (Chen, 2020), sufficient staff members, and trusting relationships. The presence of skilled social workers who offer psychosocial care and who help residents with their coping process and with communication with close relatives was also found to strengthen resilience in residents (Bern-Klug & Beaulieu, 2020; Lyng, Ree, Wibe, & Wiig, 2021). Nevertheless, there remains a lack of knowledge about which resources contribute to resilience in nursing home residents, and how nursing home residents describe the resources that they consider important when dealing with adversity. Moreover, most research about resources that give rise to resilience is based on quantitative data and does not include contextual factors (e.g., Wilson, Plouffe, & Saklofske, 2021). Hence, more studies are needed to unravel the complexity of the process of resilience in nursing home residents that include resources on all three domains. Particularly, more research is also needed on how resilience processes in nursing home residents took place during the COVID-19 pandemic, because this period of crisis presumably magnified adversity (Wister, 2022), and may have led to specific crisis-driven, innovative responses to deal with adversities (Lyng et al., 2021). This could give insight into why certain residents may have adapted better than others (Wister & Speechley, 2020).

The current qualitative study explored the lived experiences of nursing home residents and their close relatives with respect to the restrictive measures during the first lockdown of the COVID-19 pandemic in The Netherlands and Flanders, and the resources that residents used to deal with those measures.

Methods

This qualitative study was based on semi-structured interviews with residents and close relatives, and was reported following the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong, Sainsbury, & Craig, 2007).

Research Setting

The data were collected psychogeriatric, somatic and mixed wards of nursing homes in Northern, Eastern, and Southern regions of The Netherlands and Flanders, Belgium. In this article, we defined a nursing home as "a facility that provides 24-hour functional support for people who require assistance with ADL's/IADL's [Activities of Daily Living and Instrumental Activities of Daily Living] and have identified health needs" (Sanford et al., 2015, p. 183). Whereas psychogeriatric wards are for older persons with behavioural and emotional disorders caused by cognitive impairment/

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severe dementia, somatic wards consist of older persons with physical limitations but without behavioural or emotional disorders, and mixed wards consist of both types of residents. By including The Netherlands and Flanders, we acquired more insight because of variations between both regions concerning the care of older persons (e.g., small-scale living, person-centred care) and the introduced restrictive measures. The interviews were conducted with residents of 13 nursing homes and their close relatives. The capacity of the nursing homes varied from approximately 50 to more than 150 residents. During the first lockdown (from March until May 2020), 7 of the 13 nursing homes had reported cases of COVID-19 (e.g., in one nursing home, 77 per cent of the staff, and 94 per cent of the residents got infected of whom approximately 20 per cent died). During this period, most nursing homes created COVID-19 positive and COVID-19 negative spaces, and obligated infected residents to isolate themselves.

Participants and Recruitment

We applied purposive sampling for the inclusion of residents, whereby we considered a variety of background characteristics to realize a diverse group with respect to sex, age, marital status, physical and cognitive conditions (Campbell et al., 2020), and differences in COVID-19 outbreaks in the nursing homes. To be eligible for inclusion, residents had to (1) be living in a nursing home in The Netherlands or Flanders at the time of the restrictive measures during March–May 2020, (2) be able to verbally communicate in Dutch, and (3) be able to provide consent themselves, or by a power of attorney. In cases of residents with dementia, we let us be guided by the staff, who informed us whether residents had dementia or not. As long as the person considered themselves to be a close relative of a nursing home resident, we applied no specific exclusion criteria to the close relatives.

The researchers contacted various nursing homes and asked if they were willing to participate, and gave the staff an indication of how many residents with specific characteristics (e.g., with respect to sex, age) they would ideally like to interview, to realize a diverse group of residents. Staff evaluated which residents met the inclusion criteria and were suitable to participate in the study. They see the residents on a day-to-day basis and are presumably best placed to know if an interview is feasible and if the presence of a close relative or legal representative during the interview would be appropriate. They approached eligible residents and relatives and gave them an information letter in which the research objective, methodology, and ethical considerations were described.

When possible, the researchers conducted the interviews in pairs, but they also conducted individual interviews if the participants preferred this. Residents in an advanced state of dementia were interviewed in pairs whereby they answered themselves where possible, otherwise we interviewed close relatives as proxies. The participation of residents in an advanced state of dementia was always discussed with a close relative or legal representative, and if possible, the residents were informed about the purpose of the study. We conducted interviews until saturation was reached; that is, until no new themes emerged from the data.

In total, we conducted 30 interviews, for which 26 residents and 23 close relatives were recruited. Nineteen interviews were conducted in pairs, which included one resident and one close relative; and 11 interviews were conducted one on one with the participant (7 with residents and 4 with close relatives). The residents consisted of 7 men and 23 women, whose ages ranged between 57 and 101 years old. The length of stay in the nursing home varied from a few months to multiple years. Both the size and frequency of social contacts differed quite a bit among the residents. Hereby, close contacts of residents mostly consisted of close relatives, direct family, other residents, staff, and volunteers, and peripheral contacts consisted of friends, extended family, and acquaintances. Although some residents only had physical complaints, others were in a beginning or advanced state of dementia. For more information about the characteristics of the participants, see Table 1.

Data Collection

Four researchers (E.L., F.V., J.D.W., and S.N.) conducted 30 face-to-face interviews, which took place in the nursing homes between November 2020 and January 2021. The researchers wore facemasks and respected distancing and other measures that applied at the time.

The researchers used a semi-structured interview guide, which was created together with the sounding board group of the project (which consisted of health care staff, policy makers, representatives

Table 1. Participant characteristics

	% (*n*)
Residents (*n*=26)	
Country	
The Netherlands	62% (16)
Flanders	38% (10)
Age range	57-101 years
Sex	
Female	73% (19)
Male	27% (7)
Marital Status	
Single/divorced/widowed	73% (19)
Married/coupled	27% (7)
Had contracted corona virus (%)	38% (10)
Residing Ward	
Psychogeriatric	8% (2)
Somatic	46% (12)
Mix	46% (12)
Close relatives (*n*=23)	
Country	
The Netherlands	61% (14)
Flanders	39% (9)
Sex	
Female	65% (15)
Male	35% (8)
Relation to resident	
Partner	30% (7)
Daughter	52% (12)
Son	9% (2)
In-law	4% (1)
Sibling	4% (1)

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of residents and relatives, and educational and implementation specialists). After a presentation of the interview guide as developed by the researchers, the members of the sounding board group formulated their remarks, which were subsequently discussed and taken into account to improve the interview guide. At the start of each interview, socio-demographic data were collected about the residents (e.g., age, sex, marital status, type and size of ward, and if the residents had been infected with COVID-19). Subsequently, the interviewer asked the residents an open-ended question about how they experienced the restrictive measures, after which various probing questions were asked about experienced difficulties, the fulfilment of social needs, and how the residents dealt with the restrictive measures. The duration of the interviews ranged between 22 and 90 minutes, and each interview was audio recorded. Afterwards, the researchers sent a member-check (i.e., a summary of the discussion points) to the participants to approve the content, and to give them the opportunity to make adjustments or add missing information. Most participants agreed with the member-check; only minor details were adapted.

Data Analysis

All interviews were transcribed verbatim, and directly identifying characteristics were left out of the transcripts. The project team used Atlas.ti version 8 software, and applied an open, inductive method to analyze the transcripts. In first instance, five researchers (E.L., F.V., J.D.W., A.S. and S.N.) read and discussed the first interview transcript, which was subsequently coded independently by three researchers (J.D.W., S.N. and E.L.) and discussed until consensus was reached on a first set of codes. The researchers undertook the same steps for the second interview, after which the code tree was adapted and used to code the remaining interviews, which were divided among the five researchers. Each interview was coded by one researcher, and a second researcher checked the codes to increase inter-researcher reliability. All coding differences were discussed, and both researchers agreed on the final coding. In sum, the researchers gave codes to a variety of themes or happenings related to the research subject (e.g., emotions and feelings of the resident, activities, actions to deal with restrictive measures), and extracted several resources that residents used to deal with the restrictive measures (e.g., window visits, faith). After having analysed all the interviews, we used the theoretical framework by Janssen et al. (2011) to cluster and structure the resources that were inductively extracted from the data, by distinguishing among resources in the individual, interactional, and contextual domain.

Draft findings were discussed among the involved researchers throughout the analysis process. While drafting the findings, we gave each respondent a specific code to ensure anonymity. And although we did not analyse the information from residents and relatives separately, we always indicated which participant made a statement with 'P' for residents and 'F' for relatives. Although findings can be attributed to multiple interviews, quotes are always attributed to only one person.

Findings

*Almost all residents explained that the restrictive measu*res taken by nursing homes were severe stressors that negatively affected their well-being. Several of the interviewed residents had to stay in their own room during multiple weeks, ate every meal alone, had little or no contact with other residents, could no longer participate in group activities, and could not invite relatives or friends to come over. Various residents had a difficult time and experienced a lack of vitality, and some felt depressed and expressed a wish to die. But although many residents indicated that they felt lonely, some said that they did not feel lonelier than before. Although some residents explained that social contacts were important for them, others were used to being alone and did not seek to participate in group activities. "I participated little, so I lost little" (P16). Also, although some residents indicated that they did not feel afraid at all, others indicated that they felt powerless, insecure, and afraid and explained that they had to deal with the uncertainty of the situation (e.g., how dangerous and contagious the virus was).

How residents experienced the restrictive measures seemed to depend on the resources of resilience that they could access to safeguard their well-being. In the following section, we distinguish among resources in the individual domain (i.e., the ability to accept the restrictive measures, an individual's personality and ability to relativize, understanding and agreement with the restrictive measures, faith, and having solitary activities); the interactional domain (i.e., alternative possibilities for staying in contact with relatives, resistance against the restrictive measures, support by staff members); and the contextual domain (i.e., variations in local restrictions, communication, allowing residents to have a say, time and discretion of staff members), and describe how those resources interact. This is in line with the framework of resilience by Janssen et al. (2011).

Individual Domain of Resources of Resilience

The individual domain refers to qualities within older persons and includes the ability to accept the restrictive measures; residents' personality and ability to relativize, understand, or agree with the restrictive measures; faith; and having access to solitary activities.

One of the qualities that residents mentioned that they needed to maintain their well-being was the ability to accept the restrictive measures. "You needed to accept the situation, because there was no other way. If not, you become ill, when you make yourself nervous, you feel powerless and that makes you sick" (F19). However, not all residents were able to do so: "I found it difficult to accept it. I still find it [the visitors ban] a bit unjust" (P16). Second, an optimistic personality and the ability to relativize was said to influence one's coping with the situation; for example, by looking at those who have fewer contacts. "There are people who had it much worse, because we still have children" (P3). "I can relativize. […] it is more an instinct. I think I am rather optimistic. […] Therefore, when I am confronted with problems, I have no problem to wait patiently until they are solved" (P16). In this context, some residents said that they take life as it comes and are therefore able to accept the visitors ban. Third, understanding and agreement with the restrictive measures seemed to play a role in accepting the situation according to some residents: "You miss that [social contact], but I accept it because I would not want there to be any contaminations" (P12). Fourth, many residents explained how their faith helped them to accept the restrictive measures: "The fact that I am Christian is an important factor. […] It gives you strength" (P22). Finally, according to several respondents, having access to solitary activities (e.g., reading, using the computer) was an important way of gaining control over their life because it served as a distraction and made time pass. "I puzzled my way through it" (P2). However, some residents were unable to perform certain activities because of health limitations (e.g., listening to the radio

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was impossible for residents who have hearing problems): "for them it is horrible. They just sit there sitting" (F2).

Interactional Domain of Resources of Resilience

The interactional domain of resources of resilience addressed the following resources: alternative possibilities to stay in contact with relatives, resistance against the restrictive measures, and support by staff members.

First, many residents and relatives used alternative contact possibilities such as video calls, telephone calls, talking through the window or from the balcony, e-mails, and postcards to maintain contact. Numerous residents said that this was important because they felt lonely because of the visitors ban, and explained that they missed passing time with their relatives; that is, the physical contact and the emotional and practical support. A resident reported that alternative contact possibilities helped to maintain a sense of relatedness and alleviate loneliness, and according to several residents, it also served as a distraction. Further, alternative contact possibilities enabled relatives to encourage residents to remain positive, as indicated by following quote from a close relative who addressed a nursing home resident: "I think really that if we had not done it like that – with all those visits – that she would not have survived. […] We have constantly been very positive towards you. […] When you finished your drink, we made a party of it and I really think that that helped a lot, that you felt that we were there for you" (F1). However, these alternative contact possibilities were not always able to substitute for face-to-face contact, as they allowed less privacy (e.g., talking from the balcony) and not all residents could use them because of individual (e.g., hearing problems; dementia, which makes it difficult to recognize relatives) and structural barriers (e.g., living on a higher floor without a balcony, bad weather). "They once brought her to the balcony when the weather was good, but those people no longer hear well. […] If I said something, she did not understand" (F13). According to some residents, those alternative contact possibilities even enlarged negative emotions by emphasizing the difficult situation. "It was just like a prisoner behind a window waving in prison, I found that so difficult" (P14).

Second, not only acceptance of the restrictive measures, but also resistance against the restrictive measures could serve as a source of resilience because it enables residents and close relatives to have social interactions. Because alternative contact possibilities were not always sufficient to replace face-to-face contact, some residents and relatives stressed the importance of allowing one visitor at all times: "For my mother, nothing helped, except for that physical contact" (F19). For this reason, some relatives put pressure on the management to let them in the nursing home. They obtained permission from their general practitioner so that the residents would be allowed to go outside, and some residents simply broke the rules and went outside. "Every day, we went outside, walking in the garden […] But we were not allowed to do so, and they came and said that every time, but we did not really care about that" (P7). In line with this, a minority of residents comforted each other by spending the day together, despite not being allowed to do so: "You played cards every day. And in the beginning they said: 'No, no'. And then, they did it anyway. […] That was their salvation" (F7).

Third, the residents and close relatives explained that staff played a crucial role in maintaining the well-being of residents. Several residents and close relatives explicitly stated that staff was not to blame for the situation and found that staff members were helpful, caring, and proactive; gave extra attention; helped residents with alternative contact possibilities; and organized activities while respecting distancing measures (e.g., bingo in the hallway). Organising activities while respecting distancing measures was said to be important because the cessation of organised activities (e.g., cooking, singing songs, or doing physical exercises in group) minimized contacts with other residents, and led to loneliness. "The [lack of] animation is one of the most important causes of the loneliness of the people" (P14). Certain residents experienced that their bond with staff members improved during the first lockdown. "I really admire how they did it, what they organized. […] They organized so much and then also the usual care" (F4). In line with this, some residents explained how their existing relationships with their close relatives also deepened and improved during the pandemic.

Contextual Domain of Resources of Resilience

The contextual domain included the following resources of resilience: variations in local restrictions, communication, having a say, and time and discretion of staff members.

First, variations in local restrictions among nursing homes were said to affect the well-being of nursing home residents: whereas some residents were obligated to stay in their room for multiple weeks, in other nursing homes they were allowed to go outside for a walk.

Second, many residents and close relatives explained that the extent to which nursing homes and staff communicated clearly affected the well-being of residents. Communication was said to enhance understanding and acceptance of the restrictive measures. Many residents and close relatives had a lot of understanding for the nursing homes and staff and explained that they accepted the restrictive measures and understood the difficult challenges of nursing homes. "The question is not: 'Did they take the right decisions?' Because the right one will not exist. What is the right one for me is not the right one for somebody else. The question is, did they communicate sufficiently about their decisions?" (F15). According to some residents and close relatives, this was a learning process whereby nursing homes gave too little information during the first weeks, but afterwards correctly informed them (e.g., through newsletters and e-mails). Nevertheless, nursing homes that were unable to inform residents in time or were not available to answer questions were experienced as stressful, which resulted in feelings of anger and conflicts with staff. Several relatives indicated that they found the communication bad and that they missed a central information point. "So much frustration. […] Calling everybody because you do not know who you need to talk to. […] We were absolutely not satisfied with how they did it" (F3). "We had to stay inside and inside and inside and inside, for all those weeks. And we knew nothing. They told us nothing" (P7). In line with this, several relatives found the restrictive measures unclear, contradictory, and illogical, which led to conflicts with staff.

Third, various residents and relatives were of the opinion that they had too little to say with regard to the restrictive measures. Several residents indicated that most restrictive measures were simply imposed without taking their perspectives into account: "You had nothing to say" (P7). "The anger that nobody really listened to the older persons. […] That was enormously frustrating" (F22). "I think they should let people decide certain things for their own. It cannot be that because you live here, that suddenly you have nothing to say anymore" (F7). Several close relatives experienced residents as a forgotten and abandoned group. "I found the pressure from the government horrible. That

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doctors said to no longer bring older persons to the hospitals: that, I found, was the worst of all. […] Then, you are a second rang citizen […] That really hurt me" (F19). In this respect, some nursing homes discussed the restrictive measures with residents and relatives, took them seriously, and listened to their remarks, which was said to have been important for both residents and relatives.

Finally, the residents and relatives said that staff played a crucial role in maintaining their well-being and resilience. However, this appeared to depend on the available time of staff members and the extent to which they used their discretionary space. With respect to the available time, certain residents and relatives explained that staff members structurally had too little time, which worsened during the lockdown because of extra tasks and illness. As a result, several residents explained that they refrained from asking for practical help when they could avoid it, and that staff members were unable to give them extra attention or organize activities. "In the morning, noon and evening: they came to bring your food, and they were immediately gone" (F19). Further, some staff members used their discretionary space and deviated from the rules to take the specific wishes and needs of residents into account; for example, by allowing residents to meet their relatives outside or by bringing a pet belonging to a relative inside the nursing home. However, other residents and relatives explained that in the beginning staff simply implemented the restrictive measures without giving them thought, and that they were very strict and even rude and angry when residents did not follow them conscientiously. According to some respondents, this led to distress and nervousness. "We saw creative solutions everywhere on the news and the internet. That you could still visit behind glass, that sort of thing. Now, all that was not there. […] No, they were not flexible. […] They were in the beginning I think very strict: what they say from above, we execute. Not thinking for themselves at all. And certainly not looking around: how can we be creative within these rules?" (F3).

Interaction among Resources in Different Domains

In line with the framework of resilience described by Janssen et al. (2011), we observed that resources in different domains interacted with each other. The respondents explained, for example. that insufficient and unclear communication and the lack of time of staff members (contextual domain) related to a general sense of uncertainty and affected their understanding and agreement with the restrictive measures (individual domain), which in turn seemed important for the general acceptance of the restrictive measures. On the other hand, the understanding of the restrictive measures and the ability of residents to put themselves in the place of staff members (individual domain) restrained certain residents from soliciting staff members, through which staff members had more time to spend on other things (contextual domain). Further, the variations in local restrictions and the time and discretionary space of staff members (contextual domain) influenced the degree to which social interactions were possible among residents, close relatives, and staff members (interactional domain). Also, individual domain resources such as personality, faith, and having access to solitary activities were said to help some residents to (temporarily) decrease their expectations with regard to their social relations (interactional domain), and on the other hand, residents comforting each other (interactional domain) helped them to remain positive and accept the general situation (individual domain).

Discussion

This qualitative study suggested that the first lockdown of the COVID-19 outbreak was a difficult time for various nursing home residents in The Netherlands and Flanders as manifested by depression, loneliness, powerlessness, and fear. However, the lived experiences with respect to the restrictive measures seemed to vary among residents, which could be explained by their having resources that give rise to resilience, because those resources determine their coping ability. In the individual domain, the well-being of residents appeared to have been related to their ability to accept the situation, their personality and ability to relativize, understanding and agreement with the restrictive measures, faith, and having activities that they could pursue alone. The observed relationship of well-being to faith and being able to pursue solitary activities is in line with other research, which found that faith is a crucial resource (Wilson, Walker, & Saklofske, 2021) and that the capability to be active relates positively to resilience (Holston & Callen, 2021). In the interactional domain, alternative contact possibilities were said to be an important resource for residents, but not all residents were able to use them, and alternative contact possibilities were unable to fully replace face-to-face contacts. Further, some residents and close relatives showed resistance to the restrictive measures (e.g., by breaking the rules or comforting each other) and staff seemed to have played a crucial role by giving extra attention and organising activities. Finally, variations in local restrictions, communication, having a say, and the available time and discretion of staff members appeared to have been important contextual factors that influenced resilience in nursing home residents.

This study built further on the existing literature about resilience and specifically on the theoretical framework by Janssen et al. (2011). We extended this knowledge by investigating sources of strength in the specific context of nursing homes during the COVID-19 pandemic. This is important because complex resilience processes need to be studied in a larger policy framework, whereby not only individual and interactional, but also contextual factors are included (Kadowaki & Wister, 2022). Although the findings of this study are context bound, they can be useful to practitioners and policy makers in other contexts. This study focused specifically on nursing home residents who are more vulnerable and who not only had to deal with the general public health measures, but also with specific restrictive nursing home policy (e.g., obligation to stay in the own room, limited time of personnel, communication, lack of having a say). In this respect, we detected several context-specific factors that were related to the social environment and social policy, and that gave rise to resilience, such as the available time of personnel, including perspectives of residents on nursing home policy, letting residents comfort each other in small bubbles, and the communication policy.

Lessons Learned and Recommendations for Policy and Practice

A first lesson from our study is that resources that give rise to resilience varied among individuals and were determined by the specific context. Indeed, resilience is a relational construct whereby resources in the individual (e.g., ability to accept a situation) and interactional domain (e.g., encouraging close relatives to remain positive) are interrelated with resources in the contextual domain (e.g., available time of staff). Therefore, nursing homes should reinforce the resources of residents in these three domains, especially as resilience plays a central role with regard to the healthy aging of older persons (Chen, 2020). This is the responsibility of all

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actors involved, but certainly also of policy makers who can effect the necessary contextual factors (e.g. communication policy, enough time for staff members) and provide sufficient discretionary space that enables those who implement policy to tailor measures around the unique needs and possibilities of nursing home residents. This is all the more important because various psychosocial needs (e.g., the need for social contact) appeared to vary among residents, similar to feelings of loneliness.

With respect to the individual domain (Janssen et al., 2011), accepting the situation seemed an important psychological resilience process. Indeed, not accepting the situation could result in frustration and a feeling of powerlessness. Therefore, it is important to provide psychological support (Huang et al., 2020) that helps residents to accept the situation by remaining positive, maintaining perspective, and relativizing. On the other hand, giving residents the discretionary space to resist certain restrictive measures in some cases also appeared to result in more resilience (e.g., going outside for a walk while it was forbidden). This is in line with other research (McColgan, 2005) which found that nursing home residents with dementia use "resistance strategies" as a way of coping. Some, for example, feign sleep or claim a specific seat that allows distancing themselves from others to "make a public space private" and to resist being labelled as "the same as other residents". Indeed, resistance strategies against rules and routines can stimulate identity formation and regaining control, and often concern ways to reshape the home as a secure and familiar space to reinforce autonomy (McColgan, 2005).

Concerning the interactional domain (Janssen et al., 2011), it appears important to stimulate alternative contact possibilities; for example, by using digital technology (Kadowaki & Wister, 2022). However, in line with other research (Dahlberg, 2021; Vernooij-Dassen, Verhey, & Lapid, 2020), we observed that those alternative contact possibilities were unable to replace face-to-face contact and were not possible for all residents. Therefore, various residents and relatives found it crucial to take individual needs, possibilities, and limitations into account and to allow one visitor at all times; for example, in the form of "essential family caregivers" (Kaelen et al., 2021), or by organising outdoor activities (Kadowaki & Wister, 2022). Further, organising (group) activities that respect the distancing measures and allowing residents to comfort each other (e.g., in pairs or small bubbles) also appear to be important. And although contacts with relatives cannot be replaced by contact with staff members, staff members could give extra attention to compensate for the changed and often decreased contacts.

In the contextual domain, first, it appears important to provide sufficient clear and up-to-date information about the imposed restrictive measures; for example, through a central communication point (Boumans, van Boekel, Baan, & Luijkx, 2019; Huang et al., 2020). This could enhance understanding of the restrictive measures, which in turn reinforces the ability to accept these measures and alleviates frustration and conflicts (Huang et al., 2020). Second, policy should include the perspectives of residents and relatives in the decision-making process (e.g., through client counsels) because this could strengthen a sense of autonomy and competence. Many residents and relatives experienced that residents were considered an abandoned and forgotten group for whom restrictive measures were simply imposed top-down without giving them a say, which seemed to cause much distress. Third, it is important to adapt structural aspects of the building to optimize possibilities for interactions, because residents who lived on a higher floor without a balcony did not experience the lockdown the same way as residents who lived on the ground floor. Finally, in line with other research (Leontjevas et al., 2021), we observed that staff members and nursing home policy played a crucial role in the resilience of residents by giving them extra attention or organising (group) activities. However, staff members often lacked the time which made them unable to do this. Further, they also needed sufficient discretion to enable them to take the specific wishes and needs of residents into account to fine-tune the balance between safety and well-being (Kaelen et al., 2021; Van der Roest et al., 2020). Indeed, the local context must be considered, to enable organisations to stimulate resilience and to deal effectively with severe stressors (Pendergrast et al., 2021), such as the COVID-19 pandemic.

Strengths and Limitations

This study has several strengths, including the study design (e.g., through the emphasis on inter-researcher reliability), the involvement of The Netherlands and Flanders (which allows the exchange of practices and insight from different contexts), and the inclusion of both residents and close relatives. Including close relatives is an added value because they can play a crucial role in the fulfilment of the social needs of nursing home residents, as they are often aware of the wishes and needs of residents (Janssen, 2013; Reid & Chappell, 2017). There are also some limitations. First, we lack detailed information about which specific process the nursing homes used to identify and approach eligible residents, which could have involved some bias (e.g., selecting respondents who are more positive toward nursing home policy). Nevertheless, we believe that we realized sufficient diversity of respondents through the purposive sampling strategy (all respondents met our inclusion criteria and were selected from 13 different nursing homes). Second, residents without close relatives were not included in our study design, which may have resulted in an underrepresentation of people with a small social network or who feel lonely. Because some residents never receive visitors, further research should specifically aim to include those residents, for whom the experiences with respect to the restrictive measures might have been different. Third, conducting interviews in pairs (with a resident and relative) contains the risk that participants talked less openly because they might have been inclined to avoid hurting each other. Finally, the interviews took place 8–10 months after the start of the visitors' ban, which might have affected the findings, because restrictive measures and social perspectives may have changed in the meantime. Nevertheless, we believe that this time could also be a strength because it gave residents and relatives the opportunity to have some distance when reflecting on this situation.

Conclusion

The findings suggest that nursing home residents possess and mobilize various inter-related resources to positively overcome and adapt to adverse life events, and that these resources can be found in the individual, interactional, and contextual domains. Consequently, the findings of this study can be used by nursing home residents, close relatives, professionals, and policy makers to develop positive interventions that strengthen resilience and stimulate positive development outcomes. Indeed, practitioners and policy makers from diverse settings should reinforce resources in the individual, interactional, and contextual domains (Kadowaki & Wister, 2022). By advancing our knowledge of resilience during the

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pandemic, we better grasp the underlying processes that will allow us to prepare for future adversities.

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