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Registered Practical Nurses' Experiences of the Moral Habitability of Long-Term Care Environments during the COVID-19 Pandemic

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Article

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Résumé

La pandémie de COVID-19 a eu des répercussions délétères sur la vie des infirmiers et infirmières qui exercent dans des établissements de soins de longue durée, cependant les conditions morales de leur travail n'ont pratiquement pas été examinées. L'objectif de cette étude qualitative était donc d'explorer les expériences des infirmiers et infirmières auxiliaires autorisé·e·s (IAA) en ce qui concerne l'habitabilité morale des environnements de soins de longue durée en Ontario, au Canada, pendant la pandémie de COVID-19. L'étude a permis de cerner quatre thèmes : 1. S'efforcer d'assumer ses responsabilités dans un système défaillant; 2. Supporter le poids moral et émotionnel de l'isolement et de la mort des résidents dans un contexte de mesures de santé publique strictes; 3. Connaître les réalités du travail mais ne pas être entendu, reconnu ou soutenu par la direction; et 4. S'efforcer de trouver des moyens de se protéger et de protéger la profession. Il est nécessaire de prêter attention à l'habitabilité morale des environnements de travail des IAA pour entretenir un personnel infirmier de haute qualité, respectueux de l'éthique et durable dans les milieux de soins de longue durée.

Abstract

The COVID-19 pandemic has had a deleterious impact on the lives of nurses who work in long-term care; however, the moral conditions of their work have been largely unexamined. The purpose of this qualitative study, therefore, was to explore registered practical nurses' (RPNs) experiences of the moral habitability of long-term care environments in Ontario, Canada during the COVID-19 pandemic. Four themes were identified: (1) Striving to meet responsibilities in a failed system; (2) bearing the moral and emotional weight of residents' isolation and dying in a context of strict public health measures; (3) knowing the realities of the work, yet failing to be heard, recognized, or supported by management; and (4) struggling to find a means of preservation for themselves and the profession. Attention to the moral habitability of RPNs' work environments is necessary to achieve a high-quality, ethically attuned, and sustainable nursing workforce in long-term care.

Background

The COVID-19 pandemic has had an extraordinary impact on long-term care (LTC) globally, affecting the lives of residents along with their families and paid caregivers. An excess number of deaths has been reported in LTC, especially early in the pandemic (Sepulveda, Stall, & Sinha, 2020), and visiting restrictions led to the isolation, loneliness, and distress of residents and their families (Chan et al., 2022; Chu et al., 2021; Rutten, Backhaus, Hamers, & Verbeek, 2021). LTC workers have reported inadequate staffing and very high work loads (Blanco-Donoso et al., 2021; Estabrooks et al., 2020; McGilton et al., 2020; Ontario's Long-Term Care COVID-19 Commission, 2021; Sarabia-Cobo et al., 2020; White, Wetle, Reddy, & Baier, 2021) with high exposure to resident suffering (Blanco-Donoso et al., 2021; White et al., 2021), leading to moral injury (Brady et al., 2022), traumatic stress, and emotional exhaustion (Blanco-Donoso et al., 2021; Hoedl, Thonhofer, & Schoberer, 2022; Sarabia-Cobo et al., 2020; White et al., 2021).

In Canada, by the second wave of the pandemic in February 2021, 69 per cent of the total number of COVID-19 deaths had occurred among LTC residents (Canadian Institute for Health Information, 2021a). This disproportionate number of deaths has been attributed to long-standing concerns in this sector, including a lack of funding and staff, quality-of-care concerns, and a lack of integration with other sectors, despite numerous reports of significant problems

over the past 50 years (Estabrooks et al., 2020). The LTC sector in Canada falls outside of publicly funded Medicare, thereby allowing for both for-profit and not-for-profit public facilities. In the province of Ontario, for-profit homes have been of particular concern. Currently 57 per cent of Ontario's 627 LTC homes are private for-profit, 27 per cent are private not-for-profit, and 16 per cent are publicly owned (Canadian Institute for Health Information, 2021b). For-profit homes tend to offer their staff lower wages and have lower staffing levels, with high staff turnover (Ontario's Long-Term Care COVID-19 Commission, 2021). The quality of care has been reported to be lower, as demonstrated by a higher frequency of pressure ulcers, more hospital admissions, improper use of psychotropic medications, and crowded living conditions for residents (Ontario's Long-Term Care COVID-19 Commission, 2021).

Armstrong, Armstrong, and Bourgeault (2020) have commented that "The combined exposure of increased privatization and COVID-19 for those living and caring in nursing homes has emerged as a toxic cocktail with enormous consequences" (p. 448). An element of this cocktail includes the powerful context of ageism and the devaluation of care work that has led to the neglect of LTC homes (Faghanipour, Monteverde, & Peter, 2020; McGilton et al., 2020). In Ontario, registered practical nurses (RPNs) are regulated health professionals who have completed a college diploma. They have a similar scope of practice to that of registered nurses (RNs) but often work in clinical areas with less prestige (i.e., areas that are less medicalized), less perceived social value, and less pay, with approximately one third of the total workforce of RPNs in Ontario being employed in LTC (Registered Practical Nurses Association of Ontario, 2022). Many RPNs in LTC have reported frequently experiencing moral distress because they cannot provide adequate care stemming from a lack of time, restrictive workplace policies, and coworkers' varying levels of practice competence—a situation made worse by the pandemic (Registered Practical Nurses Association of Ontario, 2022).

Purpose

Understanding the ethical dimensions of LTC work environments is important because it is associated with nurses' job satisfaction, their experience of moral distress, and their turnover intentions (Koskenvuori, Numminen, & Suhonen, 2019), especially now given the deleterious impact that the pandemic has had on the nursing workforce. In addition, nurses who work in morally habitable environments; that is, settings that foster cooperation, recognition, and shared ethical responsibilities, may be more likely to enact safe and ethical nursing practice (Boakye, Peter, Simmonds, & Richter, 2021). Yet, the moral conditions of RPNs' work during the pandemic have been largely unexamined, despite RPNs' prevalence and considerable level of responsibility in LTC. Although some health care systems may no longer be responding to the immediate threats of the pandemic, it remains important to continue to study the impact of the pandemic on the nursing workforce to understand how difficult work environments can impact ethical practice and can become normalized if attention is not drawn to them adequately (Registered Practical Nurses Association of Ontario, 2022). The purpose of this research, therefore, was to explore RPNs' experiences of the moral habitability of LTC environments in Ontario during the COVID-19 pandemic.

Theoretical Framework

This study is located in a critical-social paradigm with a particular theoretical emphasis on the work of feminist moral philosopher Margaret Urban Walker (1998). Walker's (1998) work was chosen because it has the capacity to make visible the social and political dimensions of RPNs' work environments in LTC as they endeavoured to fulfill their moral responsibilities. Walker (1998) describes morality as "a socially embodied medium of mutual understandings and negotiation between people over their responsibility for things open to human care and response" (p. 9). These practices of responsibility reflect what people care about and value, to whom they are accountable, and the scope of their moral agency. Walker (1998) argues that these social-moral arrangements, however, must be made transparent to reveal what the terms and arrangements actually are, and to evaluate the moral habitability for people in various positions in them. In morally habitable environments people cooperate, display respect and recognition for one another, and fairly share both the goods and costs associated with the responsibilities that they carry. Conversely, morally uninhabitable environments are characterized by suffering, deception, oppression, a lack of accountability, and inhibition of moral agency, with the people occupying them experiencing their responsibilities as unintelligent and incoherent (Walker, 1998).

Methodology

We used a generic qualitative approach to capitalize on the flexibility of this methodology because it allows researchers to adapt methods from available qualitative methodologies to best design a study to answer its research questions (Kahlke, 2012). Our methodology was also shaped by a critical qualitative perspective to maintain coherence with Walker's (1998) feminist understanding of ethics and morality that attend to the importance of power differences in moral life. We recognized that the work of RPNs in LTC could not be fully understood without giving attention to existing power differences.

After receiving ethics approval from the Health Sciences Research Ethics Board at the University of Toronto, participants were recruited using purposive sampling through the Registered Practical Nurses Association of Ontario (WeRPN), a professional organization of RPNs in Ontario, and through word of mouth. WeRPN posted recruitment flyers in their newsletter and on their social media channels describing the research and providing contact information. Inclusion criteria included: (1) being an RPN, (2) having experience providing care in an Ontario LTC setting where there were residents with a COVID-19 infection, and (3) English fluency. We recruited a heterogeneous sample of 20 participants from across the province of Ontario: 3 from publicly owned homes, 8 from private not-for-profit homes, 8 from private for-profit homes, and 1 who worked for a nursing agency. Ten had less than 5 years of experience, with the average length of experience being approximately 8 years. This sample size allowed us to collect enough data to sufficiently answer our research questions (Malterud, Siersma, & Guassora, 2016).

Using Microsoft Teams, semi-structured interviews were conducted from December 2020 to May 2021 by authors P.B. and S.M., both experienced qualitative researchers. These interviews were audio-recorded and were approximately 45–60 minutes long. Interviews were a suitable method for data collection because they

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elicited participants' descriptions of their experiences while working in LTC during the pandemic. Participants were asked about their employment and educational background; the effect of the pandemic on their practice, especially end-of-life care; the ethical concerns and sources of stress that they had experienced; sources of actual and desired support; and the impact of colleagues, managers, and the public. The audio-recordings were deleted after the interviews had been transcribed by a professional transcriptionist. Transcripts were then de-identified and stored on a secure server.

Our reflexive posture in forming relationships with our participants and later in our interpretation of their perspectives and experiences when engaged in data analysis promoted trustworthiness (Hall & Callery, 2001). We openly discussed and made reflexive notes of our responses and assumptions that were reflections of our own identities as nurses, educators, researchers, and people impacted by the pandemic (Patton, 1999). We were particularly mindful of the fact that three of us had a history of employment in the LTC sector: one as an RN who had worked in LTC during the pandemic (P.B.), one as a former RPN (D.R.), and one as a former unregulated care provider (E.P.).

Ethical Considerations

Each participant signed an informed consent document, which described the nature of the study along with its risks and benefits, the opportunity to withdraw without penalty, data security, and procedures to maintain confidentiality and anonymity. Participants were also given the opportunity to ask questions at any time and were informed that they could choose not to answer any of the questions. Participants received a $30 electronic gift card of their choosing from three different businesses as a form of appreciation for their time. This amount was deemed not to be coercive because it is approximately the average hourly rate of RPNs.

Data Analysis

Our main analytical framework was informed by thematic analysis (Braun & Clarke, 2006). We each initiated the analysis independently by familiarizing ourselves with the data by reviewing transcripts and memoing of our emergent analytical ideas. This initial stage of coding involved the explicit coding of the data facilitated by using NVivo, which involved looking for specific, in-vivo terms used by participants (Glaser & Strauss, 2009).We then met regularly to engage in a collaborative and iterative data analysis process gradually creating tentative themes and then collapsing and separating themes to ensure that they had internal homogeneity (i.e., that the data within each theme were coherent) and external heterogeneity (i.e., there was an identifiable conceptual distinction among themes) (Braun & Clarke, 2006; Patton, 1990). Later, we employed a deductive approach to the data analysis, using key concepts from feminist ethics related to moral habitability, to add conceptual and contextual depth to the tentative themes (Eakin & Gladstone, 2020). We continued the data analysis process in an iterative fashion until coherence was achieved among the themes, feminist ethics, and the research question, and the team agreed on the core analytical characteristics and naming of the themes. Throughout, trustworthiness was attained by our adherence to data collection strategies, ethical principles, and analytic practices (Patton, 1999).

Results

Our analysis resulted in four themes, which conceptualize RPNs' experiences of the moral habitability of their work environments in LTC. The crisis of the COVID-19 pandemic made transparent in a stark manner the conditions of RPNs' work environments that inhibited their moral agency and created a significant degree of distress.

Striving to Meet Responsibilities in a Failed System

RPNs often made direct links between their struggle to meet their responsibilities as carers and the failures of Ontario's health care system to manage the COVID-19 crisis in LTC. There was an implicit expectation that those in charge of the system would understand and provide the needed conditions for RPNs to fulfill their responsibilities to residents. When this expectation was not met, participants felt betrayed and abandoned. One participant stated:

> You go to school, you pay your nursing fees, you do all the things right, and the system just is not helping in any way shape or form…You go in, you want to do your job, you want to have time to look after the residents, you want to have time to make sure all the residents are okay, but you don't. You do feel abandoned by the system. You feel rushed…It's the worst experience I think I've ever been through. (RPN 3, private-for-profit)

Others described feeling "forsaken by the government" (RPN 2, private-for-profit) and that the response of the government was merely a "Band-Aid" (RPN 6, private-not-for-profit) that soon would come off.

Some had experienced this frustration for years and called for system change and accountability, implying that the system did not respect and fulfill the needs of older adults. For example, one participant pleaded:

> Professionally, I'm hoping to God somebody listens. Somebody somewhere listens that these elderly people need care… They've worked their whole lives and then they come here, or they end up in long-term care and they get told when and what to do most of the time…And we've been yelling about it for years. And now, all of a sudden, because of the pandemic it seems to be an issue. That part, I hope, I hope, like I really, really, truly, truly do hope that somebody listens in the government and tries to figure out a way to make a better place for these people to end their lives. (RPN 10, public)

Many believed that the problems that they encountered were rooted in a system that has allowed for private, for-profit LTC homes. For example, participants said:

> They knew these private homes were cashing in quite well. They knew that the private homes were making the residents pay this amount of money but not really provide the care they should have and not having the staff they should have. They knew all of this, so yeah, the Ontario Government would be where I would put the blame. (RPN 3, private-for-profit)
>
> I find in a privately run home the goal is to make money. They will skimp and do cost saving wherever they can… They are 100 percent driven in profit. (RPN 13, public)

In contrast, one of the participants who worked in a public LTC home stated:

> I find that we were pretty calm. Calm in the sense that we had all the resources. We had all the PPE (personal protective equipment) that we

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> needed. We were never short. We got the support by getting extra staff. (RPN 11, public)

The crisis of the pandemic, particularly during the first wave, led to the introduction of stringent infection control measures, including those that restricted essential caregivers from entering care homes. The loss of their support and the increased care needs of residents, especially those infected with COVID-19, substantially increased the demands on nurses. Without a concomitant increase in staffing, participants needed to rush care and only provide what was absolutely necessary. For example, RPN 7 said: "During the pandemic most of the time we had only one nurse over there to take care of 50 residents. Yeah, 5-0. Fifty. Can you imagine? What kind of high-quality care can we give?" Similarly, RPN 20 (private-not-for-profit) said: "There were definitely so many situations and instances where we could not complete the task that was supposed to be completed, because there were not enough people to do it." Speaking of what they needed to get through the day, RPN 17 (private-for-profit) simply said: "We had to do what we had to do."

Because these participants could not fulfill their caring responsibilities, they frequently experienced acute moral suffering. RPN 3 (private-for-profit) stated:

> It was hurtful because I felt like I was letting them (residents) down and I knew that, as a nurse, I took an oath to take care of them and I wasn't doing my job. I felt bad as a person. I felt bad because I knew I was not holding up the responsibilities that a nurse should have done. Because there was just – I couldn't. I was stretched and I didn't have the time. The other nurse that works with me, she felt just the same. There were times she and I both would drive home in tears because we weren't – we knew that we weren't providing the right care that we should have been. Terrible, as a person. [pause] I just didn't feel like I was doing my job. Short-term I just get angry for a few minutes because I can't do my job. Long-term it hurts me because I feel like I'm being neglectful.

Another said:

> I felt like my moral standards were violated…When they say "patient care is the most important, and patient safety" they never did that… They desecrated, too, throughout my whole – what I believed were the most important things: like honesty, they lied about that; responsibility, they lied about that; accountability, they definitely lied about that; and yeah, they lied about a lot of things that I used to believe in. When you take those tenets away from a person, you become kind of like a shell. Because that's how I was working; that's how I created my nursing skills. That's how I've been formed as a human being…I have certain belief system that I follow, and I think about and that's what I base my actions through, and that these people have desecrated them, like, violated them, took them away, burned them, whatever. Just to have a profit. (RPN 6, private-not-for-profit)

These two quotes demonstrate the suffering that these RPNs experienced when they could not fulfill their professional responsibilities in a social-moral order that was not aligned with their approach to good nursing care. The depth of their distress signifies their sense of a violation of their deeply rooted values that defined them as professionals and as human beings.

Bearing the Moral and Emotional Weight of Residents' Isolation and Dying in a Context of Strict Public Health Measures

Many of the COVID-19 public health measures during the first wave created tensions in RPNs' capacity to meet their usual responsibilities, including end-of-life care. Most commonly, the participants spoke of the residents' isolation because of physical distancing, the use of personal protective equipment (PPE), the reduction in resident activities, and measures that did not allow for "visitors" to enter. Because participants had close bonds with residents, the impact of these measures on residents' well-being was very difficult for them emotionally and ethically especially when residents were dying. Nevertheless, their proximity to residents compelled them to do their very best despite the circumstances. One participant described their experience this way:

> I mean, it's hard because some of these residents I've cared for, for five or eight years. And I know their families well. I know them almost as well as I know the residents… To know that there's going to be restricted access in visiting the resident and being there for them. It's just heartbreaking. (RPN 1, private-not-for-profit)

The ethical concern that these public health measures produced is expressed well by RPN 13 (public):

> I've seen it personally that some residents, their food intake has dramatically dropped because they're isolated, they're eating by themselves, and they start to decline. They really do. It's really hard because it's almost like a moral conflict because I'm saying, "I disagree with this, personally, as a nurse I don't agree with this," but I have to do it because it's the public health direction.

The impact of the loss of recreation and social activity on residents was described in these ways: "They are like basically isolated from everything, from outside" (RPN 20, private-not-for-profit) and "quality of life, that has been put on hold." (RPN 13, public) In the words of the residents, as reported by RPN 18 (nursing agency): "We are like in a jail. We cannot go anywhere. We just have to see those four walls."

The visiting restrictions placed on families resulted in RPNs' experience of intense anguish and grief when they tried to support dying residents in place of family. The frequency of death, the added workload, and the need for PPE also limited how end-of-life care could be provided.

Explaining their deep commitment to residents, RPN 13 (public) stated:

> I couldn't imagine just leaving this person, who I've become close to, to just die alone. So, it's a personal thing. And I think it's just kind of who we are as people. I find that we're becoming [pause] you know, surrogate families or, you know, we're having to comfort them and take over that comforting role that – we did before but not to this degree.

RPN 5 (private-for-profit) described their experience of caring for a dying resident wearing PPE this way:

> I was covered in a yellow gown with these big goggles and this mask. That person, even if they were slightly aware of what they were seeing, they probably didn't know what they were looking at, you know? So, I just kind of felt like I was just a body that happened to be there, so that they weren't physically alone. But I mean they didn't want me there. They wanted their family. The families were, overall, fairly grateful that when we could stay with the residents that we did. But it still wasn't the same for them either, right?

Participants did their best to involve family using an electronic tablet or cell phone, but this could not compare with usual practice. RPN 1 (private-not-for-profit) stated:

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> I just found it incredibly sad that instead of the family holding their mom or dad's hand, I'm holding their hand and just holding up this video [pause] for people to say goodbye…I think that, in many ways, it made me feel like a bad nurse, especially in long-term care, because lots of our residents do end up in the palliative process and we take great pride in providing comfort in the end of life and having that connection with the family and seeing them through that.

When circumstances resulted in residents dying alone, the participants experienced significant moral suffering. RPN 3 (private-for-profit) described this in the following way:

> It impacted me very hard. It was unfair, unethical, just in all the sense words – wrong. Because they have to be isolated, so we can't – it's either isolate them or send them out. And either way they would die alone.

Similarly, RPN 14 (private-for-profit), recalling a dying resident, said:

> We didn't necessarily have the staff for someone to sit there with her while she was dying, because there was multiple of them. So, I took a picture of her family and I put it in her arms, and I was just crying. I'm like, that wouldn't have been the way it would have been prior to COVID, right?

The high number of resident deaths also did not permit participants the opportunity to grieve. They described the importance of "time to really grieve" (RPN 4, private-not-for-profit) and the need for "memorials" (RPN 9, private-not-for-profit) for residents, which were not possible. As a result, participants, described "putting up a wall" (RPN 9, private-not-for-profit) to cope and how it was "difficult to get over" (RPN 10, public).

Informing families of the death of their loved ones added to participants' grief. For example, RPN 6 (private-not-for-profit) said:

> Because these are the people who I've known: I know who their grandkids are, I know what school they go to, they bring me food, they bring me treats sometimes. They ask how my family is doing. How are you? All these things, right? And these are the people I got to know over the course of the time. So, for me it was just very disappointing – not disappointing – it was very disheartening. I'm about to break people's hearts.

Several participants spoke about the Managing Resident Death policy, a mandate issued by the Ontario government to address the large volume of LTC deaths, that changed post-mortem care of residents' bodies and added to their responsibilities considerably. RPN 5 (private-for-profit) explained:

> Of course, people have passed away there before of course, but it was so [pause] it was so much more cold and so much more impersonal, you know? Because when they died, and we had to then go wait outside and wait for the funeral home to come. And then they would pass us this gurney, and with a plastic bag, and we had to wipe everything down, and then take it into the building, and then take it up to the resident, and then put the resident in the body bag, and then wipe the whole thing down. Even them going into a bag, you know, it feels [pause] odd, right? Because you were talking to that person earlier that day or whatever. But then to have to wipe them down, you know, with the sanitizer, it just felt so [pause] very detached and strange. And then we had to write with a marker 'COVID-Positive' with a big Sharpie pen on the bag.

Some unregulated staff refused to engage in this process saying: "You know what? I'm absolutely not helping you with that. You're going to find somebody else. I just don't have it in me." (RPN 15, private-for-profit) This left the RPN to carry out this responsibility alone.

Knowing the Realities of the Work yet Failing to Be Heard, Recognized, or Supported by Management

RPNs often felt exploited by management because their proximity to and responsibility for residents kept them at the bedside. However, despite their centrality in caring for residents, they often experienced their responsibilities as incoherent in relation to how they were being treated by their managers. For example, the perception of being exploited because of their commitment and proximity to residents is illustrated in this quote by RPN 7 (private-not-for-profit):

> And you're a nurse, you know, you have responsibility. You can't let residents just stay there with no medication, nobody to feed them. So, you feel bad. You have to do it. For some managers they are not there. They just give you the task and then [pause] [chuckles] they do whatever they do. So, I think this is kind of a power of abuse. I feel I'm just like a slave.

Participants experienced a high level of exhaustion and even illness but did not feel supported or respected by management. Many spoke of feeling like they were "being punished" and "blamed for the (COVID) outbreak" (RPN 6, private-not-for-profit), feeling that "they (management) didn't care" (RPN 3, private-for-profit) that they were tired, and had their "vacation time cancelled" (RPN 1, private-not-for-profit). Similarly, RPN 17 (private-for-profit) said, "It's been very hard. It was very exhausting. I was on night shift for 12 hours, and I was working 12 days straight. So that was really, really, hard. At some point I said I'm just going to pass out." RPN 19 (private-for-profit) added: "Sometimes the staffing was so horrible that although the management knew that they (staff) were sick (with COVID), they had to call them in."

The incoherence of human resource, infection control, and practice-related rules and decisions that were being made far from the point of care without the input of RPNs was also a concern voiced by participants. Two RPNs described this situation in this way:

> Listen to us because we are with the patients more than these management. We are on their bedside. We are next to them. We are seeing them breathe. There should be something validating. So just listen to us… They know what the patients need or what they don't have or what is to be done. Just making the rules down in the office, and then posting them up on the floors cannot work, in any way. Until those rules are formed by talking and listening to the people. (RPN 19, private-for-profit)

> They were moving my residents without my knowledge or without asking if this is a good move or not. So, then they ended up moving people and they ended up getting COVID from it. (RPN 12, private-for-profit)

The participants' feelings of powerlessness and lack of recognition by management, despite their heavy responsibilities, were extraordinarily distressing for them. For example, RPN 16 (private-not-for-profit) stated:

> There is a gap of knowledge from our management, where they're not recognizing what RPNs are worth. I just think that I do feel like they could fight for their RPNs a little bit more… even dealing with the low morale and PSWs. Like, the PSWs making as much as we are? I think

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> management should address that and say, "We understand this isn't fair. We value you. We value the work you do." But we're not. I feel like I'm getting stressed just talking about it, because it's just – it's just so unfair. I don't even know what to do, and I think it makes us feel powerless.

RPN 16 (private-not-for-profit) went on to describe that the relative position of RPNs within the hierarchy of LTC often made it difficult to be heard:

> We're kind of limited in what we're allowed to do there, because management and the RNs are always, you know, they expect things to follow this proper chain of command. Does that make sense?

Most of the participants felt unsupported and unheard by management, particularly with respect to the need to cope with the ongoing crisis, along with the high number of resident deaths. RPN 17 (private-for-profit) said:

> I would have liked somebody to listen to my concerns. And, you know, if you listen to my concerns, then we can sit together and come up with a solution. Even if it's a temporary one. To listen to the rest of the staff, know what they were going through… Yeah. But you were just there to do the job, and that was it.

With respect to resident deaths specifically, RPN 9 (private-not-for-profit) stated: "I know a lot of people would have benefited from even the social worker at work going home area to home area and maybe debriefing." RPN 5 (private-for-profit) shared their concerns this way:

> I understand from an administrative point of view, and it's a for-profit home and all that, that empty beds is, you know, they're losing money… When you lose so much in a short period of time, and then the only thing that the management will talk to you about is, "No, no, we've got to get ready for new admissions." And we're thinking, "Well, what about the people that died? Can we at least talk about them? Can we do something?" No, nothing.

In contrast, one participant, RPN 2 (private-for-profit), had a very different experience from the others, perhaps because they had a different perspective as a result of being in management positions in the past. They said:

> The management team at the home where I am was excellent. As you see, I'm a little older. I have some life experience. I've worked in the corporate world. I've reported to VPs in my jobs. So, I see and understand good management, and they were excellent. Every day they were open to suggestions.

Struggling to Find a Means of Preservation for Themselves and the Profession

Participants frequently spoke about how their relationships with their colleagues helped them to continue working. They struggled, however, with whether they could continue to work in LTC given their level of stress and exhaustion, yet worried about not meeting their commitment to residents and to each other. They also raised concerns about the future of the RPN workforce. For example, RPN 8 (public) said:

> I think what's helped me, it's talking with colleagues. And even if we're joking about something, just having moments here and there where maybe we find something funny that someone says and that kind of provides that brief moment of distraction. And I think also just having opportunities here and there to speak with colleagues about your struggles and any ethical dilemmas or ethical conflicts that you might face. And trying to come up with strategies amongst ourselves or solutions amongst ourselves; it does help to talk it out. So that has been something that has helped, I would say.

Similarly, others provided examples of receiving advice (RPN 18, nursing agency), "words of support and encouragement" (RPN 4, private-not-for-profit), and the realization that they were not alone. RPN 2 (private-for-profit) simply said, "I realize that I wasn't the only one out there that was feeling the way I do."

Nevertheless, many participants expressed the inability to continue working much longer given their exhaustion, and some had already left LTC at the time of the interview. RPN 8 (public) described this situation well:

> I think people are just very much fed up with the whole situation, because I think more than anything it's exhausting people so much. It's just drained people so much of all energies and people's coping abilities…And I know a lot of people are struggling, struggling to cope.

Others spoke of feeling "overwhelmed" (RPN 18, nursing agency), "not sleeping' (RPN 5, private-for-profit), "being tormented, day in and day out" (RPN 6, private-not-for-profit), having anxiety that was going "through the roof more than ever" (RPN 12, private-for-profit), and no longer having the motivation "to advocate as much" (RPN 12, private-for-profit). RPN 6 (private-not-for-profit) also poignantly said: "I was having nightmares about me not breathing, me being zipped up in a bag."

Quitting became for many a way to escape their uninhabitable workplaces, although many struggled with the idea of not meeting their responsibilities to residents and colleagues. RPN 16 (private-not-for-profit) said:

> I keep looking at job postings, too, but I kind of have a six-month goal in mind where I'm like, okay, I'll give them the summer and then – but like, there's guilt, too, as a nurse. You don't want to leave your workplace stranded in the middle of a pandemic. That's just, that's unethical. That's not cool.

Similarly, RPN 14 (private-for-profit) said:

> The long-term implications I worry about. Not just for me but for the people I work with. I think that when COVID passes that there will be a lot of burnout in nurses particularly. I know I've heard it from a lot of people, like, 'I wouldn't leave right now but I don't know how long I can keep doing this. And this might be the end of me working in long-term care.'

Many spoke of concerns regarding the future of the profession especially for those wanting to work in LTC, because of the working conditions and low salary. For instance, two RPNs said:

> So, it really sometimes made me doubt my decision to be a nurse…Like, personally for me, the deaths we used to see, the families we used to listen to, the mess up we used to see around us, it's going to stay with me for the rest of my life, if I ever go back into a nursing home. I'm not even really willing, even willing to work in a nursing home right now, just because of the thought that, oh, the floors are going to be understaffed. If I go there, I'm not going to have proper resources. I'm not going to have a good management, right? (RPN 19, private-for-profit)

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> They're trying to find nurses, but nobody is staying, nobody wants to do it, nobody wants – because for this pay and for that load of work, nobody wants to do it. (RPN 18, nursing agency)

RPN 6 (private-not-for-profit) simply asked: "And now who's going to be left to care for people?"

The need to be heard by the public and to make transparent the social-moral conditions of their work was made plainly evident with one participant saying:

> We have all these people and they're saying: "Nurses are heroes." That is very nice. But when you come and you sit and you just have a little dialogue with us, you know, listen to us, let us vent! Let us vent. (RPN 11, public)

Similarly, the hollowness of some of the public support was expressed by RPN 15 (private-for-profit) when they said: "At this point, like every time I hear, 'Thank you, healthcare heroes' I just, I want to barf."

Others also spoke of their participation in our research as a means to make changes, with one participant saying: "I'm so glad that there are people that are studying what has happened, and hopefully will help give long-term care a voice for some change" (RPN 1, private-not-for-profit), and another saying: "To share the experience and, I know this is for research, maybe it'll bring light to others what we have already gone through" (RPN 9, private-not-for-profit).

Discussion

In this qualitative study, we explored the moral habitability of the work environments of RPNs who provided direct care to LTC residents during the COVID-19 pandemic. This research is a form of transparency testing in that it helped make visible the social-moral arrangements (Walker, 1998) of RPNs' work environments during the height of the COVID-19 deaths in LTC. Unambiguously, the findings point to the lack of moral habitability of work environments in these settings. Participants suffered because they could not meet their moral responsibilities to residents despite their best efforts, and they experienced their nursing identities as damaged when their sense of integrity and deeply held values of providing compassionate and individualized care to residents were violated.

Although these nurses understood the importance of public health measures, as in other studies (Chan et al., 2022; Chu et al., 2021; Peter, Mohammed, Killackey, MacIver, & Variath, 2022), they painfully witnessed the isolation of residents when these measures, such as visiting restrictions and physically distancing, conflicted with their other important responsibilities such as providing close relational care. The lack of staff and other resources, exacerbated by the pandemic, created conditions in which they could not provide the kind of end-of-life care that these residents deserved, which created not only moral suffering, but also unresolved grief that may impact their willingness to stay not only in LTC but also in nursing altogether.

Participants' proximity to residents, being close to residents both emotionally and socially, along with being in the same time-space, compelled them to act and experience empathic distress (Nortvedt & Nordhaug, 2008; Walker, 1998). This proximity is inherent in the nature of their nursing work and as such, led them to take responsibility to continue to provide care and return to work despite the precarious working conditions and their own risk of infection. Unfortunately, their proximity resulted in a heightened sense of accountability for residents' care far beyond what they could be reasonably asked to provide. It also created a context in which they understood the needs of residents in ways that their managers could not and led to their commitment to support residents and their colleagues despite their wish to find alternative work.

It is noteworthy that one of the three participants (RPN 11) who worked in a public, not-for-profit home spoke more favourably about their working conditions because they received extra staff and had adequate PPE. This differential in resources may point to the incompatibility of profit motives with those that prioritize the care of residents. Nevertheless, this participant, like the rest, wanted to express their frustrations with the problems of the LTC system, which they recognized originated in government policies and practices. These RPNs blamed the government, which they believed to be unaccountable for their working conditions and the treatment of residents. On the one hand, RPNs had tremendous responsibilities for the lives and well-being for LTC residents, yet on the other, they experienced little structural or decision-making power in the system, exposing what Walker (1998) would identify as the type of incoherent moral responsibilities characteristic of a morally uninhabitable environment. Participants also called attention to how the current injustices in LTC are a manifestation of the long-term lack of public investments in this sector that had occurred before the pandemic. The disregard for the care needs of older adults because of government policies uncovered government's practices of responsibility and the apparent lack of value accorded to their lives and needs, typically attributed to ageism (McGilton et al., 2020). Preshaw, Brazil, McLaughlin, and Frolic (2016) describe ageism as the "silent contributor" (p. 497) that lies at the core of ethical problems in nursing homes, reflecting broad societal attitudes that have led to the conditions present in nursing homes.

To foreground this broad political context of RPNs' work, we intentionally chose to frame our work using the concept of moral habitability, as opposed to moral distress. Typically, the type of distress that these participants experienced has been labelled "moral distress", which has been defined as arising when "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984, p. 6). Although the experiences of these RPNs could be accurately called "moral distress" according to this definition as it has in previous research (Edwards, McClement, & Read, 2013; Pijl-Zieber et al., 2018; Spenceley, Witcher, Hagen, Hall, & Kardolus-Wilson, 2017; Young, Froggatt, & Brearley, 2017), we wanted to make visible that the constraints that they encountered were rooted in systems beyond those in their institutions. Participants expressed, generally without prompting, the political sources of their distress, calling for action and accountability on behalf of the government and the public.

The significance of this research is threefold. First, it functions as an extreme example of the impact of RPNs' working conditions on their moral lives. Second, it signals what could happen if these conditions continue and become normalized and third, it provides some evidence regarding what can sustain the overall well-being of this workforce, including its moral well-being into the post-pandemic.

Unquestionably, the reality of these RPNs' work environment during the early part of the 2021 pandemic in Ontario was not typical given the evolving nature of public health measures and the lack of vaccines. Nevertheless, the nature of the core of their moral concerns is not new. A lack of resources, especially insufficient staff,

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has been frequently identified in Canada and internationally as a significant moral issue for nursing home staff because it leads to inadequate care, reduced standards, and a lack of ongoing education (Pijl-Zieber et al., 2018; Preshaw et al., 2016; Spenceley et al., 2017). It also leads to significant challenges in providing excellent end-of-life and person-centred care, both held to be central to the aims of nursing homes (Preshaw et al., 2016; Young et al., 2017). In 2022 in Ontario, 93 per cent of RPNs reported unsafe working conditions, with their workload continuing to increase over the previous 2–3 years with 79 per cent of them reporting moral distress (Registered Practical Nurses Association of Ontario, 2022). Notably, 27 per cent of the WeRPN respondents were working in LTC at the time of this survey. It is important to recognize that these conditions are of ethical consequence and reveal the ongoing lack of moral habitability of RPNs' work environments beyond the crisis points of the pandemic.

Given that conditions are continuing to deteriorate, there is indication that these working conditions are becoming normalized (Registered Practical Nurses Association of Ontario, 2022). Unsurprisingly, 40 per cent of respondents to the Registered Practical Nurses Association of Ontario (2022) survey who were working in LTC were thinking of leaving, with 27 per cent of them no longer wanting to work as RPNs in any setting, because of their level of distress and feelings of being devalued. To preserve a sense of moral identity these nurses, like those in previous studies (Peter, Simmonds, & Liaschenko, 2018; Varcoe et al., 2004), needed to have a sense of being appreciated and valued for their skill and commitment to care along with a need to do "right" despite constraints, a situation made more critical given the effects of the pandemic. In addition, participants valued the opportunity to participate in this study, expressing not only their need to share their experiences but also their desire for transparency in organizational decision making and input into policies and procedures that directly impact their day-to-day clinical work. This situation foretells an ongoing crisis not only in terms of RPNs' well-being but also in terms of serious ethical implications for the well-being of nursing home residents and the inability to increase the capacity of nursing homes.

No doubt, increasing the resources for this workforce would enhance the moral habitability of their work environments; however, we discovered that the relationships that nurses had with other colleagues at the bedside and with each other were a source of strength and a place where there was mutual understanding of their shared responsibilities. As in other studies (Peter et al., 2022; Peter, Mohammed, et al., 2022), including another Canadian study that included LTC nurses and care aides (Hung et al., 2022), these relationships formed pockets of support and moral habitability in otherwise highly challenging environments. Despite the significance of these relationships, close to half of RPNs in Ontario report experiencing increasing isolation from colleagues, with less time to foster these relationships (Registered Practical Nurses Association of Ontario, 2022).

Limitations

There are several limitations in our study. The COVID-19 pandemic continues to evolve, resulting in this research being a limited snapshot in time. These participants tended to think back on the worst time of the pandemic when vaccines were not always available and public health measures were in constant flux. Yet, the benefit of time having past has also given us a sense of the longer-term consequences of the pandemic that have been described in local reports, such as that of Registered Practical Nurses Association of Ontario (2022) and international reports such as that of the International Council of Nurses (2021). These speak to the crisis that health care systems are encountering in attracting and retaining nurses, given the impact of the pandemic on nurses' health, including their moral well-being. In addition, this research was conducted in only one Canadian province, with a unique LTC system, and despite the problems we discovered, Canada is a high-income country with more health care resources than most other countries globally. Ultimately, these unique characteristics limit the transferability of the findings.

Conclusion

The importance of attending to ethics and the moral habitability of work environments for nurses is essential when addressing the crisis in LTC. Ontario's Long-Term Care COVID-19 Commission (2021) concluded: "Leaders at every level must put their hearts, as well as their minds, into reimagining the care of the elderly in this province. This will require a philosophy of care that is anchored in respect, compassion and kindness for the people who live and work in long-term care. It is not just about building more homes." (p. 21) The rebuilding of the LTC sector post-pandemic must account for the moral conditions of RPNs' work, to ensure that these nurses find meaning in this skilled caring work, and to sustain their long-term presence in direct care given the challenges of practice in this field. Future endeavours to address the LTC crisis must invest in working conditions that facilitate the moral identities of RPNs as valued carers of older adults. Our study illuminated that the moral commitment that RPNs hold towards LTC residents, many of whom were described by participants as family, compelled these RPNs to stay in morally uninhabitable environments. Future considerations must capitalize on the relational proximity of RPNs to promote ethical nursing care, rather than exploit this commitment to initiate unsafe practice environments. Moving forward, institutional structures in LTC must be also developed for RPNs to have input into their working conditions, gain trust from decision makers, and feel supported and acknowledged for undertaking caring work that has been traditionally devalued by the system and the culture of health care. Without attention to the moral conditions of RPNs work environments, high quality, ethically attuned, and sustainable nursing care in LTC will not be possible.

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