Medical Research Archives

European Society of Medicine

OPEN ACCESS

Published: February 29, 2024

Citation: Liljas, A., E.M., et al., 2024. Views of medically responsible nurses and managers of care homes for older adults on communication of information on Covid-19: a case study in Greater Stockholm. Medical Research Archives, [online] 12(2). https://doi.org/10.18103/mra.v12i2.4981

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DOI:
https://doi.org/10.18103/mra.v12i2.4981

ISSN: 2375-1924

RESEARCH ARTICLE

Views of medically responsible nurses and managers of care homes for older adults on communication of information on Covid-19: a case study in Greater Stockholm

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ABSTRACT

This study explored the views of medically responsible nurses and managers of care homes for older adults in Greater Stockholm on communication of information during the first wave of the Covid-19 pandemic. Study participants consisted of managers of care homes for older adults (n=10) and medically responsible nurses (n=4). Semi-structured interviews were conducted between 5th and 30th November 2020. Data were analysed thematically. Findings show that both medically responsible nurses and managers of care homes experienced the information from different authorities during the first wave of the pandemic to be inconsistent and uncoordinated, which caused stress particularly among the managers. Some managers expressed that they would have wanted more assistance from the medically responsible nurse. Some managers created their own support networks to share ideas and resources. The medically responsible nurses also reported being overwhelmed by information, and that they tried to condense it and only disseminate relevant parts to the care home managers. The role of medically responsible nurses in the municipality varied locally. Some had a more managerial role within the municipal leadership, while others also to some extent worked hands-on and frequently visited local care homes. Before the pandemic their contact with care home managers was not very frequent, and for some the relationship was worsened during the first phase of the pandemic. Yet, in some cases the medically responsible nurse successfully acted as an important player linking information, guidelines and data share between authorities and care homes. In conclusion, this study suggests that there is a need for clarification of the roles and responsibilities of the different actors in the health and social care of older adults in Sweden including the role of medically responsible nurses. The findings of this study also stress that information from authorities needs to be adapted to those targeted.

Introduction

The Covid-19 pandemic hit Sweden hard, particularly in the early phases during 2020 and especially among older adults. About 90 percent of deaths occurred among persons aged 70 years and older and half of those were among residents in care homes for older adults and 25 percent of deaths were among those receiving home care.[1] Older adults who reside in a care home have close contact with members of staff and other older residents on a daily basis, which makes it difficult to practice social distancing.[2] For example, modern care homes are often built to bring people together and provide a homelike atmosphere, however as seen during the Covid-19 pandemic, this also contributed to difficulties in isolating residents to prevent spread of infection.[3,4] Studies have shown that information on how Covid-19 spread including the role of asymptomatic transmission changed how care homes for older adults organised their work.[5,6] Whilst information is critical to prevent infection, too much information, known as 'information overload', has been reported to be conflicting and have adverse effects.[7,8] Following the Influenza A (H1N1) pandemic in 2009, American research reported on communication between public health authorities and clinicians showing that clinicians felt overwhelmed by the number of emails received from public health authorities.[9] However, research on the experiences of communication between authorities and staff in the care sector during the Covid-19 pandemic is sparse. Further, a recent study on the experiences of managers of home care services in Stockholm has reported differences in organizational strategies on how to handle the pandemic both between different municipalities and service providers.[10] These differences might to some extent be explained by Sweden's decentralized systems: The responsibility for health and social care among older people in Sweden is divided between the 20 regions, which provide healthcare services, and 290 municipalities, which provide social care. Municipalities are responsible for long-term care of older people, including care homes, and are obliged to employ one or more medically responsible nurses who ensures that healthcare guidelines to organisations in the municipality, such as care homes, are followed. Medically responsible nurses also collect data on new cases of infectious diseases in the municipality including records of infections provided by care home managers. Further, both health and social care are tax-funded and may be delivered by public or private providers. Private care organizations may furthermore have their own medically responsible nurse(s). Medically responsible nurses have their own networks to exchange ideas and support each other. In some municipalities, medically responsible nurses are part of the municipal steering group.[11]

Both health and social care are tax funded and may be provided by public or private providers. During the pandemic and in the aftermath of the pandemic, issues have been raised concerning shortcomings in the organization of care of older people, lack of collaboration between health and social care and unclear communication and lack of guidelines regarding the care of older people in the pandemic.[12,13] This includes that actions to tackle the Covid-19 outbreak sometimes were taken too late or were inadequate to protect older adults against the virus. A report

by the national Corona Commission further showed that in the early phases of the pandemic, care home managers and staff often experienced that they had to handle the crisis themselves.[14] Managers of care homes for older adults organise the work of their employees who primarily consist of nurse aides and care assistants who work in shifts to ensure that there is staff available 24-7. Care homes for older adults also have daytime nurses employed by the care home, by the care organization of the municipality, or by a private provider funded through taxation, who look after the older adults in the care home daily. Medical doctors allocated to certain care homes visit residing older adults in need of their expertise about once a week. Additionally, nurses and medical doctors are available on call 24-7. Care home managers further handle their own administration. They report on their work and finances to the local municipality which also follows up any incidents, and that laws are followed. Managers of care homes are sometimes part of a management team at the municipality from which they also receive information about, for example, policy changes and new guidelines. Managers of private care homes may also have internal guidelines and management teams.

Methods

Purpose of the study

To explore the views of medically responsible nurses and managers of care homes for older adults in Greater Stockholm on communication of information during the first wave of the Covid-19 pandemic.

Study design

This is a descriptive qualitative research study with a case study design. Case study design was chosen as it allows for knowledge-gain on a specific topic i.e. experiences of and actions taken to prevent and control Covid-19 infection, in a specific setting i.e. care homes for older adults.[15]

Study setting and participants

Study participants consisted of managers of care homes for older adults (n=10) and medically responsible nurses (n=4) in Greater Stockholm, Sweden. Sixteen care homes were purposively sampled for variety in type of organization (public/private), geographical location (urban, semi-urban) and size using the website of the local government listing all 151 care homes (31 public and 120 private care homes). The managers of these care homes were telephoned and informed about the study and their participation rights. Twelve care home managers were scheduled for an interview based on their availability. The phone call was followed by an email with information about the study in writing, consent form, and date and time for the interview. Two care home managers considered the work situation too strained to participate. Additionally, two of the scheduled interviews were cancelled by the participant due to time constraints. Informed consent was obtained in writing or verbally recorded before the interview questions were asked. None of the participants were known to the researchers. Ethical approval was received by the Swedish Ethical Review Authority (2020- 04577).

Data collection

An interview topic guide was developed through discussions within the research team inspired by existing literature.[16] Topics covered included access to and use of resources including personal protective equipment (PPE) and actions taken to prevent and control spread of the coronavirus. Participants were also asked to describe their work and the provide overall information of the care home. A pilot interview was conducted and minor amendments to the order of the questions were made. The semi-structured interviews were undertaken one-to-one by female researcher AL who has multiple experiences of conducting interviews part of qualitative research studies. The same researcher undertook all interviews.

The interviews were conducted between 5th to 30th November 2020 when the second wave of the pandemic hit Stockholm, restricting all interviews to be carried out by telephone or videocall using Zoom. Each interview lasted for about one hour, was audio recorded using a Zoom H2n Handy Recorder, and transcribed verbatim by the same researcher or a professional transcriber. Identifiable information in the transcripts was anonymized. The researcher took field notes after each interview. Audio recordings and interview transcripts were uploaded and stored on a server protected by two-factor authentication at the university where the researchers are affiliated.

Data analysis

Thematic analysis was used to analyse the data.[17] The interview transcripts were read by the two researchers AL and JA who individually identified tentative codes and patterns. These were discussed, revised, and refined as two transcripts were coded together by the researchers. The remaining transcripts were coded by AL using NVivo. The two researchers combined the codes into categories which were further grouped into sub-themes and an overarching theme. The translations of codes, themes, and quotes from Swedish to English were discussed to make the translation as accurate as possible. Interpretations of the results were drawn collectively by the team.

Trustworthiness

Rigor of the study was ensured by transparent reporting of the research process. Credibility and dependability were sought by using a well-established research method and analytical approach, involving two researchers in the identification and application of codes, and providing detailed information of the research process, allowing the reader to assess the research practice. Confirmability was sought by supporting the results by quotes from the participants, and by involving at least two researchers in all analytical parts, reducing the risks of analysis bias by allowing for multiple interpretations of the results. Transferability of the study to other contexts was sought by describing the phenomena studied, the setting and the informants.

Results

Characteristics of informants

Ten managers from ten different care homes for older adults and four medically responsible nurses operating in three different municipalities in Greater Stockholm, were interviewed. Half of the care homes (n=5) were privately operated, of which two

were not-for-profit. Three care homes had less than 50 apartments, four care homes had 50-99 apartments, and three care homes had more than 100 apartments. Generally, there was one older resident per apartment. Of the four medically responsible nurses, two worked in urban areas and two worked in semi-urban areas of Greater Stockholm.

The role and responsibilities of medically responsible nurses

The medically responsible nurses explained their variety in work tasks including checking that healthcare guidelines and agreements are followed, and facilitating organizational changes related to care provided at municipal level. Some also commented on the variety in the work undertaken by medically responsible nurses in different municipalities. *"To some extent, it's a question of interpretation [of the role] as some take a more overarching role and think that they shall be at organizational level whereas others choose to also spend time taking part in the work on the ground"* Medically responsible nurse 112320-1633

Medically responsible nurses with an overarching role valued having such position: *"I find it useful to have the overall responsibility. It is not for me to meddle in the internal work at a care home and at the same time make overall decisions."* Medically responsible nurse 111620-1303

Reported benefits of having an overarching role included being better informed: *"In some municipalities the medically nurse has an overarching role, and that medically responsible nurse has a helicopter perspective. We're part of the same regional network for medically responsible nurses, and I've noticed that they are more up-to-date on the latest information thanks to their overarching role, I can really tell the difference."* Medically responsible nurse 111820-1013

Some medically responsible nurses became a member of the municipal Covid-19 steering committee during the pandemic. *"Still I think my commitment as the municipal medically responsible nurse needs further clarification and regulation in terms of its organizational role."* Medically responsible nurse 111820-1013

Managers of private care homes reported that they primarily have contact with their internal medically responsible nurse who then liaise with the municipal medically responsible nurse: *"As a private company, we turn to our medically responsible nurse. [We take] everything with her."* Care home manager 111320-1157

Frequency in contact between care home managers and medically responsible nurses

Care home managers reported little contact with the medically responsible nurse prior to the pandemic. One manager reported that before the pandemic they attended group meetings with the municipal medically responsible nurse 2-3 times per year. Some other care home managers reported that before the pandemic, they initiated telephone contact with the medically responsible nurse a few times per year. Most care home managers reported intensified communication with the medically responsible nurse during the Covid-19 pandemic. *"Under normal circumstances we don't have much contact, we communicate on the phone or via email. Now the situation is different, on some days we have spoken with the medically responsible nurse five times in one day"* Care home manager 111320-1157

The medically responsible nurses provided a similar picture of frequency in contact with the care home managers in their geographical area prior to the pandemic: *"[I contact the care home managers in my area] about two times per term. [Apart from these two times] if anything else comes up, they contact me. … Sometimes they get in touch. Not very often, only occasionally, their business is handled where they are."* Medically responsible nurse 111620-1303

In some cases, little contact continued during the pandemic too. A couple of care home managers and one medically responsible nurse who operated in the same semi-urban area reported little or no contact with each other: *"I meet them [care home managers] on Skype. I have… during spring I haven't been out much. I've been working from home a lot."* Medically responsible nurse 112720-1725

One care home manager who had experienced an early Covid-19 outbreak in their premises were unsatisfied with the amount of contact and support from the medically responsible nurse: *"She [the medically responsible nurse] telephoned me once, that was after I had complained and then she called."* Care home manager 110420-1523

Information exchange between care home managers and the medically responsible nurse

Covid-19 specific work tasks allocated to the medically responsible nurse by the municipality varied substantially. Whilst some medically responsible nurse primarily continued working on an organizational level and offered support to care home managers upon request, other medically responsible nurses collected incidence and prevalence data on Covid-19 on a daily basis, which required frequent contact with the care home managers. *"There is variety in how demanding the municipal medically responsible nurses are. Our medically responsible nurse does not demand much whereas my colleagues in [other geographical areas] have to report upon everything they do. … In spring [2020], every morning, our medically responsible nurse requested a daily update by email. The number of infected [older adults], and the number of infected employees. They were interested in the number of confirmed and suspected cases, and also information about those who had recovered. Later, this was only requested twice weekly. Currently, it's not daily, like it was back then."* Care home manager 110620-1131

Medically responsible nurses' roles in administering and distributing information from authorities

The medically responsible nurses reported extensive amounts of information being provided by authorities as the pandemic hit Sweden. All of them commented on and reflected upon their role in distributing information: *"In the beginning, there was an unbelievable amount of information and emails making it difficult to know what was new. … Everything was passed on to everyone to ensure that no one had missed out on anything. … For several weeks there were a lot of emails that I also circulated, and in hindsight I should have acted differently."* Medically responsible nurse 112320-1633

Medically responsible nurses explained how they tried to separate information received

from authorities and pass on information relevant to the different services they work with such as care homes for older adults: *"We haven't passed on information about routines for care homes to the hospitals, and vice versa. Such information was separated. … We decided not to reword but use the text provided by the national and regional authorities."* Medically responsible nurse 111620-1303

Dividing and allocating information to be distributed to relevant target groups was considered challenging and time consuming: *"I'd say that it was a mission impossible. You really had to take out [information] based on your instinct and knowledge when deciding what [information] to include and what to skip. Because of the inconsistency in the information, this was a testing experience that was immensely time-consuming."* Medically responsible nurse 111020-0932

Examples of only sharing the most essential information included a medically responsible nurse who following the experience of stressful situations with care home managers further cut down on the messages circulated. *"In the first few weeks, I emailed the care home managers too much information. They [care home managers] only want the most important information and so I added a couple of sentences what it was about. But when speaking to them on the phone I realized that no one had time to read what I had written. I could tell they were panicking. Then I initiated reconciliations. I knew that things need to be documented and will be evaluated and so I started summarizing things on one single PowerPoint slide. I asked for feedback on the information provided and what information they needed and any clarification needed. I learnt a lot."* Medically responsible nurse 112720-1725

One medically responsible nurse explained how including her in the municipal covid-19 steering committee facilitated distribution of information and enabled understanding for each other's expertise: *"The senior management team didn't like that I emailed them information with weblinks. They recognized that things had to be done differently. That's how they realized that the medically responsible nurse should be part of the committee."* Medically responsible nurse 111820-1013

As the second wave hit Stockholm, the medically responsible nurses interviewed had taken actions including developed and distributed guidelines for care home managers. *"If we had known that this would happen, one could have prepared various documents in advance. ... Now we've collated everything care home managers need to know in a book."* Medically responsible nurse 111020-0932

Care home managers' experiences of lack of support in organising information

All care home managers expressed frustration regarding the amount and frequency of information from different authorities that they to some extent also experienced to be inconsistent. *"Sometimes I find it difficult when they [different authorities] say things that are not fully in line with other directives. That's difficult. And sometimes it says 'recommended', 'should', and 'must' about the same thing and that's confusing – is it a recommendation or a requirement?"* Care home manager 111620-1102

Most care home managers thought that the local municipality responsible for care homes in their area could have demonstrated greater commitment and support in organizing information. *"We received tons of emails and instructions, and we didn't have the time to read it [during the first Covid-19 outbreak]. We barely had time to check our emails as we worked non-stop. We needed support. Information should have been compiled and distributed by one single sender. It was very hard to stay up-to-date on recommendations and at the same time ensure that we had enough staff onsite for each hour of the day, 24-7."* Care home manager 110420-1523

Some care home managers had positive experience of working closely with the medically responsible nurse: *"The medically responsible nurse has helped us and forwarded guidelines and emergency plans, yes… we have received a lot of information from the medically responsible nurse throughout [the pandemic]. And we [the medically responsible nurse and the care home manager] have discussed what to pass on to the nurses, what to be distributed to our staff. I think this is very important. The right information to the right person and not everything to everyone, because some [information] may not be relevant."* Care home manager 111820-0846

All care home managers thought that one of the greatest weaknesses during the first wave was that information distributed from national and local authorities was not coordinated. This was also considered a massive problem among the medically responsible nurses. All informants further thought that the vast amount of information circulated was very time consuming to go through. *"No one tied things up. I had to search for everything myself. Someone should have separated the information [into] 'this is relevant, this can be thrown away'".* Care home manager 110620-1335

Care home managers identifying the support needed

All care home managers reported some kind of external support to be essential to undertake their work during the first wave of the Covid-19 pandemic. For some care home managers, the municipality provided the support needed. *"In our geographical district, the municipality has been very caring asking how we are getting on and if there is anything they can do to support us. They have constantly had a dialogue with us and I find that very nice."* Care home manager 110620-1131

Care home managers who did not receive the support they needed from the municipality, sought support elsewhere. One care home manager reported having regular contact with the senior consultant (chief medical officer) at a local hospital from whom they received the latest information and consulted regarding specific situations.*"[Through meetings] I get to meet the senior consultant weekly. So it comes naturally to me to turn to [that person]. The senior consultant tries to provide the information [that I ask for] or let me know where I can find such information."* Care home manager 111120-0932

Several care home managers reported that they had sought support from other care home managers. Typically, municipal care home managers turned to each other, and care home managers of private companies turned to their company. Examples included

intensified collaboration between municipal care home managers who operated in the same geographical area and knew each other well. *"Because of the coronavirus, we faced challenges like staffing, and so we started lending staff between us when the situation was strained. Lending staff had not crossed our minds before but during such a crisis we had to do that. … We helped each other a lot with practical advice and outlined written plans. But some [care homes] were already hit [by a coronavirus outbreak]. Still other care home managers could provide help. This was peer support, not [municipal] senior management support."* Care home manager 110420-1523

Having support further seemed to make care home managers more confident in their role. *"I feel confident working with our medically responsible nurse. … But I have noticed that others are unsure and do not feel confident in how to act and since many have no other manager on-site, they are left to what others say and think."* Care home manager 111620-1102

Possible reasons for the inadequate response to the pandemic on municipal level

According to one medically responsible nurse, poor preparedness included not having fully considered care homes as the primary setting for the virus: *"Home care service providers, their managers, all of us thought that the home care sector would be hit the hardest. Not the care homes."* Medically responsible nurse 112720-1725

Another medically responsible nurse commented on the care home managers' workload: *"I find municipal care home managers' commitment too comprehensive to fulfil. They simply can't keep up with such workload."* Medically responsible nurse 112720-1755

Discussion

Both medically responsible nurses and managers of care homes for older adults experienced the information provided by different authorities during the first wave of the pandemic to be inconsistent and uncoordinated. This is consistent with previous research on care managers and medical staff,[10,18] exploring experiences of healthcare workers and staff in the care sector during the Covid-19 pandemic reported contradictive information within the organization based on unclear guidelines on personal protective equipment. Yet the current study is one of the first studies during the Covid-19 pandemic to include a focus on how staff in the care sector experienced information from authorities.

The vast amount of information distributed further caused stress, particularly among care home managers. Lessons learnt from the Influenza A pandemic could have reduced such burden as research has from that pandemic in 2009 has concluded that emails should be sent from one single credible source such as a local healthcare institution, new information should be highlighted so that professionals do not have to search for it, and explanations to be provided to local recommendations that differ from national recommendations.[9] Further, most of care home managers reported that they would have preferred more assistance including support from the medically responsible nurse.

The current study shows that to compensate for the absence of support from the medical responsible nurse, care home managers supported each other or identified support elsewhere including other professionals. This adds to the findings of a survey completed by 909 nurses in elderly care and 202 medically responsible nurses across Sweden in summer 2020, just a few months into the Covid-19 pandemic. In the survey, lack of support from the medically responsible nurses was reported by 43% of the nurses who answered the questions. In the current study, in addition to mental support, practical support was reported to be provided between care home managers in the form of exchange of ideas and resources, between medically responsible nurses through their network, and between medically responsible nurses and care home managers who collated and condensed information from authorities into shorter and targeted messages. The findings add to existing studies and reports on the work of the medically responsible nurses and challenges they faced during the pandemic by suggesting that the role and responsibilities of the medically responsible nurse needs to be further clarified.[19,20] Indeed, this study shows that the role of medically responsible nurses in the municipality was not clear, and practices varied locally and between municipalities, according to interviewees. Some medically responsible nurses had a more managerial role within the municipal leadership, while others worked more on the ground, assisting in care homes. Before the pandemic their contact with care home managers was not very frequent, but this increased during the first phase of the pandemic. In some cases, the medically responsible nurse could successfully act as the "broker" of information from authorities, collating new information and discussing with care home managers and staff how to apply the new guidelines into their routine work. During the pandemic, a government investigation on roles and responsibilities of different actors in health and social care of older adults in Sweden was launched. A proposal for legislation was presented in 2022 and includes strengthening the healthcare competence in the social care sector with specified responsibilities for municipalities and regions.[21] The proposal further suggests the role of the medically responsible nurse to be embedded in a more regulated leadership structure to ensure medical competencies in municipalities. Such regulated leadership structure has however been criticized by stakeholder organisations to potentially have adverse effects should the financial resources of the municipal be inadequate.[22,23] The Swedish Nurse Association has also criticized the proposal for not clarifying the role of the medically responsible nurse in detail, and suggested that clarifying their role would be more beneficial than regulated leadership.[23] The proposal is currently under review. If accepted, it may influence future investigations, proposals and laws including a new law on social services. However, the proposal does not take a holistic perspective and may therefore not bridge existing gaps between healthcare and social services, potentially causing care inequity in the ageing population known for having the greatest needs of both healthcare and social care.

Another lesson learnt from the experiences of the informants during the pandemic is that information from authorities needs to be adapted to those targeted. Besides

competencies in identifying and summarizing information concisely, this study shows that ability to adapt the presentation of such information to appropriately target end-users requires time and reflection. This adds to the aforementioned findings of the study on the Influenza A pandemic suggesting that apart from using a single credible sender and highlighting new information,[9] the information distributed should also be adapted to those targeted. Better adapted information has the potential to make communication more efficient both in everyday work and during a crisis. Yet, this would first need to be an established work method to fully function even when there is staff turnover or a crisis.

Strengths and limitations

Study strengths include that both public and private care home managers were interviewed, and that medically responsible nurses operating in the same municipalities were interviewed too providing views from more than one perspective. The number of interviews was relatively small, challenging the generalizability of the study. Further, the risk of recall bias is considerable as the time period covered is long; from the start of the pandemic until November 2020. Still, it is a strength that all interviews were undertaken within four weeks in November 2020 meaning all informants referred to the first wave of the pandemic.

Conclusions

This study suggests that there is a need for clarification of the roles and responsibilities of the different actors in the health and social care of older adults in Sweden including the role of medically responsible nurses. The findings also stress that information from authorities needs to be adapted to those targeted.

Author Contributions Statement

BB and AL planned the study. AL conducted the interviews. AL and JA coded the transcripts. AL, JA and BB interpreted the results. AL wrote the manuscript with input from BB and JA. Everyone has read and approved the final version.

Conflicts of Interest Statement

The authors declare no conflicts of interest.

Funding Statement

The study is funded by The Swedish Research Council (Vetenskapsrådet) (2020–05850).

Acknowledgements

The authors thank the participants for their participation.

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