Are they immune?
The impact of COVID-19 in Nursing Homes

A qualitative study into the effect of COVID-19 on the organisational structure and thereby the quality of working life in nursing homes.

Name: Nick Oosting
Student number: S1030878
E-mail: nick.oosting@student.ru.nl
Master: Business Administration
Specialisation: Organisational Development & Design

Supervisor: dr. Lander Vermeerbergen
Second examiner: dr. Stefan Schembera

Date: 06/07/2021

Abstract

Nursing homes in The Netherlands are facing a huge challenge right now. In the previous years the workload and time pressure has increased. But last year it even increased more. The COVID-19 pandemic has had an enormous impact in the care sector and also in the nursing homes. Many nursing homes in The Netherlands were facing infections and even the death from residents because of COVID-19. Because of the virus, nursing homes were obligated to take measures to prevent the spreading of the virus. One of these measures was a lockdown, so no one could visit their family in the nursing homes. These measures had an effect on the organizational structure. The care workers needed to perform more tasks than normally. This study addresses the impact of COVID-19 on the organizational structure and the effect of these changes on the perceived quality of working life of care staff workers. In order to get insight in this phenomenon, 14 respondents are interviewed, and document analysis has been done. The document analysis is done to get an insight in the organizational structure and to analyse an employee satisfaction survey. The findings indicates that the quality of working life has decreased over the last year. For the care workers it was hard to get all the tasks done and because of the lockdown they needed to take over tasks. Support tasks like delivering food and cleaning homes were not part of their routine tasks. This organizational structure change has led to high time pressure, which causes the care staff workers to scale down care. Scaling down care is something that was hard for the care staff workers because taking care over the residents is the most important part of their jobs. During the COVID-19 pandemic, the autonomy of the care workers decreased. An extra department was built to make the COVID-19 policies. Because of the continuous changes of policies and the centralized policy making, they had no influence on the policies that were made. Besides the organizational structure changes, other factors also have had a negative impact on the quality of working life. Working with measures like face masks and suits, was something that the care workers experienced as awful and caused them mental and physical complaints. So, these organizational structure changes and extra measures caused that the quality of working life of care workers has decreased.

Keywords: Organisational structure, COVID-19, Quality of working life, Nursing home, Care worker

Table of contents

Chapter 1 Introduction 5
Chapter 2 Literature review 8
2.1 Quality of working life 8
2.1.1 Job Demand Control Model 8
2.1.2 Job Demands 10
2.1.3 Job Control 10
2.1.4 Social Support 11
2.2 Organisational structure 12
2.2.1 De Sitter MST 12
2.2.2 Regulatory capacity and high job demands 13
2.2.3 Parameters 14
2.2.3.1 Production parameters 14
2.2.3.2 Control structure 16
2.2.4 Parameter values 18
2.2.4.1 Effect of parameter values on the production and control structure 18
2.2.4.2 Impact of values on quality of working life 20
2.3 COVID-19 crisis situation 21
Chapter 3 Methodology 23
3.1 Research design 23
3.2 Data collection 25
3.3 Sensitizing Concepts 27
3.4 Data analysis 27
3.5 Quality of research & Ethics 30
3.6 Timeline 32
Chapter 4 Results 33
4.1 Organisational structure 33
4.1.1 Structure before COVID-19 33
4.1.2 Organisational structure changes because of COVID-19 38
4.2 Quality of working life changes because of structure changes 41
4.2.1 Job demands 41
4.2.2 Job control 43
4.3 Changes because of COVID-19 43
4.4 Quality of working life because of COVID-19 46
4.4.1 Job demands 46

4.4.2 Job control 51
4.4.3 Social support 53
Chapter 5 Discussion & Conclusion 57
5.1 Interpretation of results 57
5.2 Theoretical contribution 60
5.3 Practical implications 61
5.4 Limitations, future research and reflection 63
References 65
Appendix 75
Appendix 1: Interview guide 75
Appendix 2: First contact mail 77
Appendix 3: Data structure 78
Appendix 4: Research Integrity Form 105

Chapter 1 Introduction

In March 2020 the World Health Organization called COVID-19 a pandemic (WHO, 2020). That is why nursing homes in The Netherlands are currently facing a huge challenge. This is featured by news site NOS (2021), which had the following headline *"also in the northern part of the country dramatic stories from nursing homes"*. An article of newspaper AD (2020) shows the pressure on the care sector *"Nowhere else is as much absenteeism due to illness as in healthcare: work pressure is high "*. Even before COVID-19 the high workload was already there according to the news site Nursing: *"Work pressure in nursing and care homes is too high"* (Nursing, 2013). These articles show the urgency and the increasing workload in the healthcare sector. In this study the focus is on the impact of COVID-19 on the organisational structure and thereby on the perceived quality of working life of care staff workers during the COVID-19 pandemic.

Even before the COVID-19 pandemic the workload was already high (Franzosa et al., 2019). Care staff workers in the elderly care in The Netherlands are providing more complex care to their patients. The complexity comes from the fact that their patients need more attention and that the activities they must perform have become more diverse (De Veer, Frankce, Poortvliet & Eliens, 2007). Care staff workers say that they also need to work more according to standard procedures. The rising complexity and working according to standard procedures have a negative impact on the quality of working life of the care staff workers (De Veer et al., 2007). The ageing population challenges the nursing homes, because there are more patients to take care of (Lagergren, 2002; OECD, 2009). The combination of the increasing retirement in the sector causes an even bigger problem and thus more time pressure on the care staff workers (Salar, 2009; NBHW, 2009). Time pressure is an important factor in the quality of working life (Karasek, 1979). The workload was already high prior to COVID-19, but it increased even further as a result of COVID-19 (Maslach, Jackson & Leiter, 2020).

There are different ways to design elderly care. In some of the research they studied the impact of customer-oriented design. According to Loe and Moore (2012) customer-oriented design has positive sides for elderly care. The idea behind this is to give patients a 'homelike' environment to give them the impression of their previous everyday life and give them the feeling of being 'home' (Lopez, 2006). According to Lopez (2006), however, this method is unlikely to enhance working conditions. Care staff workers must be more customer-focused while providing higher-quality care to residents (Korczynski et al., 2000). This new way of working means that the care workers are more *"physically and emotionally attached to the residents"* (Vermeerbergen, McDermott & Benders 2020 p. 2). Many care staff workers face challenges combining their work as care staff workers and their duties for their family (Crompton, 2006; Simon, Kümmerling & Hasselhorn, 2004; Burke & Greenglass, 1999). During the COVID-19 pandemic this has become a bigger problem (Maslach et al., 2020; White,

Wetle, Reddy Baier, 2021). Residents ask for more help and they have to be careful with not infecting the residents. This bigger challenge causes more workload (Maslach et al., 2020; White et al., 2021).

In the COVID-19 pandemic nursing homes are in the front line of the pandemic (Cohen & Tavares, 2020). Furthermore, COVID-19 has been confirmed in nursing homes all over the country. During the pandemic there is an increase in deaths in nursing homes, they account for the majority of deaths in a lot of countries (Adalja, Toner & Inglesby, 2020). Because of the many deaths and easy spreading of the virus, nursing homes became "ground zero" of the COVID-19 pandemic (Barnett & Grabowski, 2020; Stall, Farquharson, Fan-Lun, Wiesenfeld, 2020). People with long-term care are more vulnerable and COVID-19 is spread more easily among elderly people (Barnett & Grabowski, 2020). The rapidly increasing cases of COVID-19 in nursing homes causes more workload for care staff workers (Maslach et al., 2020; White, Wetle, Reddy Baier, 2021; Mo & Shi, 2020). Furthermore, care staff workers need to take measures to prevent spreading the virus. They need to wear protected clothes and also COVID-19 patients need to wear protection like face masks. These measures to prevent spreading the virus are increasing workload and have a negative impact on the quality of working life (Lucchini, Lozzo & Bambi, 2020; Giuliani, Lionte, Ferri & Barbieri, 2018). Other key stressors for care staff employees include living with death and dying as a result of COVID-19, a lack of emotional preparation, and treatment unpredictability.. The fact that the care staff workers are the last people that the patient will see before they die puts a huge amount of pressure on the care staff workers (Neto, Almeida, Esmeraldo, Nobre, Pinheiro et al., 2020; Said & Shafei, 2021). This pressure brings emotional exhaustion to the care staff workers. Emotional exhaustion is an important factor in the quality of working life (Bakker, Demerouti & Euwema, 2005. High emotional exhaustion can have a negative impact on the quality of working life (Karasek, 1979). It is even the most common reason for a burnout (Blatter, Houtman, Van den Bossche, Kraan & Van der Heuvel, 2005).

Quality of working life and the organisational structure are related to each other. According to De Sitter (Achterbergh & Vriens, 2019) the organisational structure of the organization can lead to higher quality of working life. In their theory they discuss different organisational structures which can be hierarchical or more functional. These are pillars to develop an organisational structure which contributes to the quality of working life in the organization (Achterbergh & Vriens, 2019; De Sitter, 1994). Workload can be seen as one of the parts of quality of working life, in combination with for example emotional exhaustion and time pressure (Karasek, 1979) In the study of Karasek (1979) there are several job demands which cause different types of quality of working life. Some job types cause higher workload, emotional exhaustion and time pressure which is affecting the quality of working life (Karasek, 1979).

In most of the research the focus was on the design for quality of working life for care staff workers or for quality of life of the residents. The study of Loe and Moore (2012) was focused on customer-

oriented design. In the study of Boumans, Berkhout, Vijgen, Nijhuis & Vasse (2008) the focus was on the demand. This study emphasizes the movement from traditional care to integrated care. They state that integrated care should bring more quality of working life. The conclusion shows that the improvement of quality of working life was limited (Boumans et al., 2008). Researchers mainly focused on the impact of organisational structure on the quality of working life of nursing homes during non crisis situations. In this study there will be another context, I will look into the effects of a crisis situation on the organisational structure, and the impact these changes have on the quality of working life of care workers in nursing homes. In this study the crisis situation referred to is the COVID-19 pandemic.

In a public health crisis, like COVID-19, there should be measures in nursing homes to prevent the spreading of the virus. It is important to have enough care workers to take care of the inhabitants. During a public health crisis, the workload can rise because of measures that should be taken (Lucchini et al., 2020; Giuliani et al., 2018). Besides these measures, residents ask for more care and this is causing more workload (Maslach et al., 2020). Also because of the increasing infections among care staff workers, there is more absenteeism, and this is also increasing the workload (White et al., 2021; Mo & Shi, 2020). An important factor here is quality of working life. Reducing workload, emotional exhaustion and time pressure causes better quality of working life and employee well-being (Sjöberg, Pettersson-Strömbäck, Sahlén, Lindholm & Norström, 2020; Clegg, 2001; Karasek, 1979). The amount of workload, emotional exhaustion and time pressure is an important indicator of the quality of working life of the employees (Manz & Grothe, 1991; Karasek, 1979). Not only the workload is important, but also the control over this workload. The autonomy of care staff employees has declined as a result of COVID-19 instability (Said & Shafei, 2021). This is due to the fact that management protocols, official recommendations, and policies are updated on a regular basis (Said & Shafei, 2021). This means that the care staff workers have less control over their job demands (Karasek, 1979). The balance between job demands and control over this workload (job demands) is important for the quality of working life (Karasek, 1979). COVID-19 can be seen as a crisis situation. By studying the impact of a crisis situation on the organisational structure and then the effect of organisational structure on quality of working life, the organization can see what is necessary, in terms of organisational structure, to retain quality of working life during a crisis situation. By retaining quality of working life, care staff workers can take the best care for residents and also be productive (Pavlish & Hunt, 2012).

This research will give an answer to the following research question, by using a comparative qualitative case study: *"How does COVID-19 infections of residents affect an organisational structure and thereby the quality of working life of care staff workers in high and low COVID-19 locations?"*.

The structure of this thesis will be as follows. To begin, the theoretical background of the thesis will be discussed in chapter 2. In this chapter the quality of working life and the organisational structure pillars will be elaborated. In the next chapter, chapter 3, the data collection, research method, data sources and data analysis method will be discussed. Besides those topics also the quality of the research and the ethics will be discussed. After the methodology part of chapter 3, the findings of the research will be discussed. In chapter 5 the practical and theoretical relevance will be explained and also the limitations of the research.

Chapter 2 Literature review

In this chapter the theoretical background of this study will be discussed. This part will be separated by the concepts. First of all, there is the concept of quality of working life. For this concept I will use the research of Karasek (1979). The second concept is about the organisational structure, which will be built around the theory of De Sitter (1994). This study will be conducted during a crisis situation. In the third concept there will be discussed what a crisis situation is.

2.1 Quality of working life

To understand the concept of 'quality of working life', it should be explained first. There are multiple definitions of quality of working life. In the study of De Sitter (1994) quality of work was about the meaningfulness of organisational jobs. And whether there are opportunities created for employees to "live a fulfilled life" (Achterbergh & Vriens, 2019 p. 63).

2.1.1 Job Demand Control Model

The study of Karasek (1979) is built around the ability of employees to learn and develop themselves. In this study the focus is on the Job Demand-Control Model of Karasek (1979). The study of Karasek (1979) distinguishes two constructs: job demand and job decision latitude. According to Visser, Schouteten & Dikkers (2019) job demands can be seen as "*those physical, psychological, social or organizational aspects of the job that require sustained physical and/or psychological (cognitive and emotional) effort of skills and are therefore associated with certain physiological and/or psychological costs"* (p. 44). Karasek (1979) defines job demands as *"psychological stressors involved in accomplishing the workload"* (p. 291). The second construct is job decision latitude. In the study of Karasek (1979) it is defined as "*the working individual's potential control over his tasks and his conduct during the working day"* (p. 289-290). Job control (decision latitude) influences the care staff workers' well-being and the physical health of the care staff workers (Ganster & Fusilier, 1989; Parkes, 1989; Warr, 1987). The possibility to plan their work and take initiatives, is defined as decision latitude (Karasek, 1979). Employees with high decision latitude can handle high job demands because decision latitude refers to how much power they have over their work (Karasek, 1979). So, it

can be concluded that employees perceive stress when they have high job demands and low decision latitude.

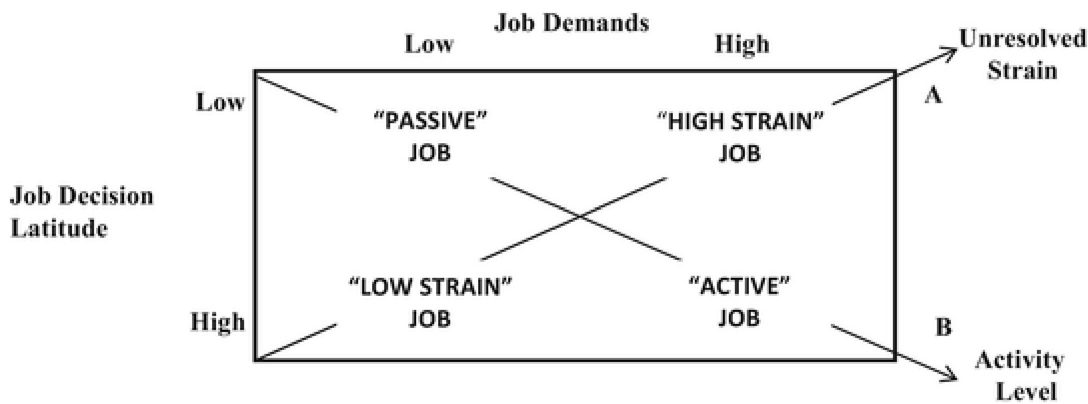

Figure 1: Job strain model (Karasek, 1979 p. 4)

The Job Demand Model of Karasek (1979) shows two lines namely A and B. Besides those lines the model distinguishes four job types. The idea behind line A is that when the job demand rises and decision latitude decreases, the job strain will increase. So, if an employee has less control over their job and the demands are higher, employees will perceive more stress (Karasek, 1979). In previous research there is shown that this is the case in a lot of nursing homes (Backman, Sjörgen, Lovheim & Edvardsson, 2018; Edberg, Bird, Richards, Woods, Keeley & Davis-Quarrell, 2008; Edvardsson, Sandman, Nay & Karlsson, 2009, Morgan< Semchuk, Stewart & D'arcy, 2002). High job strain is associated with burnouts (Backman et al., 2018; Maslach, Jackson & Leiter, 1996; Blatter et al., 2005; Schaufeli & Houtman, 2000). One of the most common sources of burnout is emotional exhaustion. This can be characterized by feeling empty, being exhausted and mental hollowing, as a result of the job (Blatter et al., 2005). In the nursing homes, a burn out is something that is common (Lev & Ayalon, 2018; Shahar, Asher & Ben Natan, 2019). In a research conducted in the South Netherland, they saw that 16% of the sample had a burnout (Kant, Jansen, Van Amelsvoort, Mohren & Swaen, 2004). The main reason for this burnout was mental illness (Blatter et al., 2005; Kant et al., 2004). Most of these psychological problems are caused by stress (Blatter et al., 2005). Line B shows a different effect. When the job demand and job decision latitude increase, the job will become more active. An active job means that the employee will learn and develop new behavior. In this way they are able to deal with the high job demands (Karasek, 1979). The Job Demand Model of Karasek (1979) has been broadened.

In the study of Karasek & Theorell (1990) social support was added to the model. The influence of social support on high-strain jobs was investigated by Karasek and Theorell (1990).. Social support can be seen as support from colleagues, friends, managers, peers, patients and a network around you (Karasek & Theorell, 1990; Backman et al., 2018), Jobs with high demands, low decision latitude and also a low degree of social support are in more risk of developing illnesses (Johnson & Hall, 1988;

Karasek & Theorell, 1990). Because of low social support employees could perceive higher strains (Karasek & Theorell, 1990).

2.1.2 Job Demands

According to Bakker, Demerouti & Euwema (2005) the most essential aspects of job demands are workload and emotional demands.. Job demands are thus important parts for stress, which has an impact on the employees physical and mental capabilities (Schaufeli & Bakker, 2004). High job demands are one of the reasons why employees are absent (Bakker, Demerouti, De Boer & Schaufeli, 2003) or facing health problems (Hakanen, Bakker & Schaufeli, 2006). Job demands can also have a positive impact. For employees it is important to have a certain level of job demand to be motivated and perform their tasks (Karasek, 1979). When the job demands will become too high, this can have a negative effect (Fila, 2006; Karasek, 1979). In the study of Chong & Monroe (2015) they state that the excessive workload that comes from high job demands, and a lack of control are related to emotional exhaustion. In the study of Karasek (1979) job demands are defined as *"a combination of psychological stressor involved in accomplishing the workload, stressor related to unexpected tasks, and stressors of job-related personal conflict"* (p. 291). Karasek mostly focuses on the psychological stressors which involve work pace and time pressure (Karasek, 1979). In this study the focus will be on the psychological stressors used in the model of Karasek (1979). The workload for care staff workers in nursing homes is high (Maslach et al., 2020: White et al., 2021) and they face a personal conflict because of the duties they have for their family and for their patients (Crompton, 2006: Simon et al., 2004; Burke & Greenglass, 1999). Because of the mental exhaustion and the unexpected tasks, the care staff workers face right now in the COVID-19 pandemic, this study uses the model of Karasek (1979) to define quality of working life. So, in this study job demands will be seen as stress conditions coming from high workload. To get a better idea of job demands in nursing homes this will be discussed next. The ageing population challenges the nursing homes, because there are more patients to take care of (Lagergren, 2002; OECD, 2009). The combination of the increasing retirement in the sector causes an even bigger problem and thus more pressure on the care staff workers (Salar, 2009; NBHW, 2009). And not having the right resources or the ability to give the care needed is also a possible stressor for the care staff workers (Edberg et al., 2008). The emotional demands are high for the care staff worker because of the high workload and dealing with death of the residents (French, Lenton, Walters & Eyles, 2000), resident aggression (Rodney, 2000) and deterioration of the patient (Broday, Draper & Low, 2003).

2.1.3 Job Control

In order to be able to deal with high job demands, job decision latitude could help to lower the strain (Karasek, 1979). High job demands are especially problematic when there is a lack of job control (job decision latitude) (Karasek, 1979). Then the employees are not able to control demands and can't get

the job done (Karasek, 1979). Job decision latitude consists of two types of components: decision authority and skill discretion (Carayon, 1993; Karasek, 1979). Decision authority can be seen as the authority that the employee has over their own decisions and the decisions that have an impact on their work (Del Pozo-Antunez, Ariza-Montes, Fernandez-Navarro & Molina Sanchez, 2018; Karasek, 1979). Skill discretion is about the amount of freedom the employee has to use their own skills or knowledge to their jobs (Karasek, 1979). When there is low skill discretion this leads to high emotional exhaustion and low person accomplishment (Rafferty, Friend & Landsbergis, 2001). Job decision latitude is also about employee decision authority, which means the opportunities to participate and opportunities to use skills and knowledge (Karasek, 1990). According to Holden (1991) nurses and care staff workers should have sufficient knowledge, power and authority to have autonomy. Autonomy for nurses consist of four themes namely ‘to have a holistic view’, ‘to know the patient’, ‘to know that you know’ and ‘to dare’ (Skår, 2010). One of the main points here is the relationship between the patient and the nurse. They emphasize that this is very important, but because of a lack of time it is sometimes difficult to prioritize the nursing tasks (Skår, 2010). The autonomy of care staff employees has declined as a result of COVID-19 instability (Said & Shafei, 2021). This is due to the fact that management protocols, official recommendations, and policies are updated on a regular basis (Said & Shafei, 2021). So, in this study decision authority will be seen as an opportunity to make their own decisions that affect their jobs and skill discretion as the amount of skill and knowledge that the employee can apply to their jobs. A common part which is causing stress and eventually job strain is the lower levels of education and the small number of possibilities to discuss difficult cases (Edvardsson et al., 2009). Low levels of education could cause a low level of skill discretion. Care staff workers with a higher level of autonomy feel more connected to the nursing home (Goon, Kim, Hwang & Lee, 2013). This could be an important factor in the control of the job for care staff workers.

2.1.4 Social Support

In this study social support will be included to determine the perceived quality of working life. Different research has shown the positive impact of social support (Orrung Wallin, Jakobsson & Edberg, 2015; McGilton, Hall, Wodchis & Petroz, 2007; Edberg et al., 2008; Viswesvaran, Sanches & Fischer, 1999). Social support even has a positive impact on the employee's job demands, job satisfaction, and health of the care staff workers (Burke & Greenglass, 2001; Johnson & Hall, 1988), some research even indicates a positive effect on burnout complaints (Dierendonck, Schaufeli & Buunk, 1998). Emotional exhaustion and depersonalization, both types of symptoms of burnout, are strengthened by a lack of social support (Bakker, Demerouti & Verbeke, 2004). As mentioned before, types of social support are friends, family, peers, patients, network around you and managers (Karasek & Theorell, 1990). Peer support is vital because a lack of opportunities and support from peers, the employee, and especially new employees, can lead to a lot of stress on the workplace

(Vermeerbergen et al., 2020). The patients in the nursing homes also play a role in the social support. According to the study of Prins, Hoekstra-Weebers, Gazendam-Donofrio, Van de Wiel, Sprangers, Jaspers & Van der Heijden (2007) there is a correlation between the social support of patients and the emotional exhaustion and depersonalization. Disappointment of informative support has a negative effect on the depersonalization and the dissatisfaction of appreciative support has a negative effect on emotional exhaustion (Prins et al., 2007). For the nursing homes social support of managers is very important in dealing with high job demands (McGilton et al, 2007; Fagerberg & Kihlgren, 2001). The idea is that a high degree of social support could prevent high job strain (Karasek & Theorell, 1990; Backman et al., 2018; Viswesvaran et al., 1999).

2.2 Organisational structure

In the literature there are different definitions about organisational structure (Thompson, 2007; Mintzberg, 1980; De Sitter, 1994; Christensen, 2009). Mintzberg, Thompson, Christensen and De Sitter are common theories used for organisational structure. The study of Thompson (2007) is mostly focused on predictability and adaptability. In which way should an organization be structured to keep those two in balance and keep the coordination costs as low as possible (Thompson, 2007). In the study of Mintzberg (1980) the focus is mostly on effectiveness. Mintzberg defines a set of parameters who affect the structure. These parameters should be aligned in order to get effectiveness (Mintzberg, 1980). Christensen (2009) is focused on affordable healthcare and making healthcare accessible for everyone. By disrupting the organisational structure, Christensen tries to make healthcare accessible (Christensen, 2009). The last study is from De Sitter (1994), this study focuses on three essential variables namely, quality of organization, quality of working relation and quality of work. To reach these variables certain parameters are determined. These parameters represent a certain organisational structure (Achterbergh & Vriens, 2019). In this study the research question is about the relation between the organisational structure and the quality of work. This is why De Sitter (1994) is most suitable for this research.

2.2.1 De Sitter MST

De Sitter distinguishes three criteria, as mentioned before. In this study only quality of working life is important. Quality of working life will be measured based on the Job Demand Model of Karasek (1979). According to the study of De Sitter, there are two types of structures namely, production and control structure (Achterbergh & Vriens, 2019; De Sitter 1994). The production structure is about grouping and coupling of operational tasks and control structure is about the grouping and coupling of regulatory tasks (Achterbergh & Vriens, 2019; De Sitter, 1994). First the production structure is built, from broad independent flow (macro) to small teams (micro). After the production structure is built, the control structure will be built. This goes the other way around, from small (micro) to broad

(macro) (Achterbergh & Vriens, 2019; De Sitter, 1994). These structures are influenced by parameters which will be elaborated further on in this chapter. To achieve the quality of work requirement the organisational structure should reduce disturbances and should increase regulatory potential (Achterbergh & Vriens, 2019; De Sitter, 1994). In this study quality of working life is central, whereas in De Sitter (1994) they refer to it as quality of work.

2.2.2 Regulatory capacity and high job demands

In the study of De Sitter (1994) quality of work is part of external requirements. De Sitter (1994) sees quality of work as the meaningfulness of jobs and which possibilities there are to deal with possible work-related stress. Looking at the definition there are some interfaces with the study of Karasek (1979), to deal with work related stress can be seen as job decision latitude, which is the way how employees can control their work (Karasek, 1979). Quality of work in the study of De Sitter consists of three parts namely, the stress conditions (job demands), the opportunity to be involved and the opportunity to learn and develop (skill discretion and decision authority) (Achterbergh & Vriens, 2019; De Sitter, 2000). In the study of De Sitter (1994) stress condition came from the model of Karasek (1979) (Achterbergh & Vriens, 2019). High job demands can cause high workload and mental labor, those two in their turn can cause stress for the employees (Karasek, 1979). In the study of De Sitter (1994) regulatory capacity is a way to deal with high job demands, also known as job decision latitude in the study of Karasek (1979). The regulatory capacity gives the employees the opportunity to deal with their work-related high job demands (Achterbergh & Vriens, 2019). In order to deal with the high job demands, employees should have a balance between the high job demands and the job decision latitude (Bakker, Schaufeli & Demerouti, 1999; Karasek, 1979).

As mentioned above it is important to have a balance between regulatory capacity and job demands. Some important parts are job enlargement (higher job demands) and enrichment (higher job decision latitude) (Bakker et al., 1999; Karasek, 1979). When those two are high this can lead to lower stress and a more meaningful job. When there is only job enlargement this will still lead to a higher opportunity of stress (Achterbergh & Vriens, 2019). There is a risk of stress in a position with high workload and little regulatory capacity. Employees may regard their occupations as straightforward at times, especially when workload and regulatory capacity are low (Achterbergh & Vriens, 2019). It is thus very important how tasks are allocated and how the design of the organization is built. There should be a balance between workload (job demands) and regulatory capacity (job decision latitude) to be able to meet the external requirement quality of work (Achterbergh & Vriens, 2019; De Sitter, 1994; Vermeerbergen, Pless, Van Hootegem & Benders, 2018; Vermeerbergen, Van Hootegem & Benders, 2016).

2.2.3 Parameters

In the study of De Sitter (1994) there are seven parameters discussed. These parameters are related to the organisational structure of an organization. In order to reach the goals these parameters should have as low as possible values. De Sitter distinguishes two types of structures, the production structure which consists of three parameters and the control structure which consists of four parameters. In the next section the production parameters will be discussed.

2.2.3.1 Production parameters

As described before the production structure is about grouping and coupling of operational tasks (Achterbergh & Vriens, 2019). The first three parameters in the study of De Sitter are concerned with the production structure. The production parameters are the degree of functional concentration, the degree of differentiation of operational activities and the degree of specialization of operational activities (Achterbergh & Vriens, 2019 p. 54).

Functional concentration can be described as *"the degree to which operational tasks are related to all order types"* (Achterbergh & Vriens, 2019 p. 55; Kuipers, van Amelsvoort & Kramer, 2018). In this definition order types refers to the *"individual demand for a product or service"* (Achterbergh & Vriens, 2019 p. 55). For example, a patient group, like Alzheimer or residents with physical problems, delivered by a care staff worker. An order type can be seen as a part of all order types (Achterbergh & Vriens, 2019). In organizations there are often more than one order type. When all operational activities are related to all order types, there is high functional concentration (Achterbergh & Vriens, 2019; De Sitter, 1994). In organizations with high functional concentration you often see operational units, this is a clustering based on similarities of activities, knowledge or skills (Achterbergh & Vriens, 2019).

Looking at nursing homes, high functional concentration could be that care staff workers are related to all resident's types (Mohr & Dessers, 2019). An example of high functional concentration is that nurses and care staff workers need to wash patients from different departments like, Alzheimer and physical problems. This is an example of functional departments, all operational tasks, in this example washing the patients, are coupled to all residents (Mohr & Dessers, 2019). In order to reach external requirements, quality of work, values of the parameters should be as low as possible (Achterbergh & Vriens, 2019; De Sitter, 1994). A low degree of functional concentration means that operational tasks are not related to all order types, but only to one or maybe a few (Achterbergh & Vriens, 2019). To reach a low degree of functional concentration order types should have their own set of operational activities, which means that they have their own personnel and equipment (Achterbergh & Vriens, 2019). In the best-case scenario, operational activities are only linked to one order type, resulting in a low degree of functional concentration. Applying this to the nursing home case this means that the

care staff workers only see a specific type of residents (Mohr & Dessers, 2019) In the example of patients with Alzheimer and physical problems this means that a group of nurses and care staff workers only wash patients with Alzheimer and another group of nurses only wash patients with physical problems. Now the tasks are not set in a functional department, which is the case in a high degree of functional concentration (Mohr & Dessers, 2019). In some organizations this is not possible given a certain context like a too small number of patients. In this case organizations could have an intermediate functional concentration, which means that operational activities are only coupled to a few order types (Achterbergh & Vriens, 2019). But it is important that these operational activities are only dedicated to those order types and not to the other order types who are not coupled (Achterbergh & Vriens, 2019; De Sitter, 1994). The idea behind the functional concentration is to build independent flows, who are not dependent on each other (Achterbergh & Vriens, 2019). All in all, the desired state is that organizations have as much independent flows as possible.

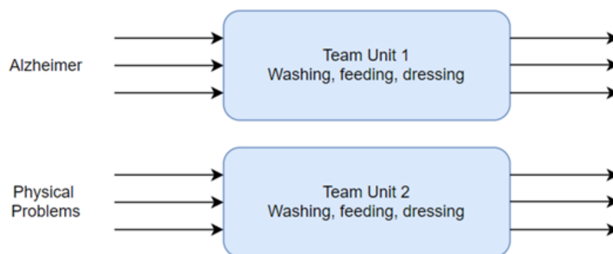

Figure 2: Low parameters values on functional concentration

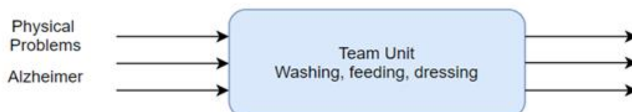

Figure 3: High parameter values on functional concentration

The second parameter of the production structure is the degree of differentiation of operational activities. This is about the differentiation of the activities production, preparation and support (Achterbergh & Vriens, 2019; Kuipers et al., 2018). Production and preparation activities are directly related to the orders, while support has an indirect link to the orders. There is a high degree of differentiation if all the three activities are separated. The degree of differentiation of operational activities is low when operational tasks include production, preparation and support activities (Achterbergh & Vriens, 2019). In the case of nursing homes production can be seen as the nurses and care assistants who take care of the residents, preparation as the planning of the work schedule and support as the cleaning of the nursing home, cooking for the resident, HR and administration (Pless, Dessers & Van Hootegem, 2016). High degree of differentiation of operational activities means that the operational activities are grouped in separate tasks. This suggests that the caregivers are mainly

responsible for their residents' medical needs and do not cook or clean for them. A low degree of differentiation of operational activities means that the planning, HR, administration, cleaning and cooking are coupled together in one task. The desired situation in the organisational structure is that the operational tasks production, preparation and support are coupled together.

The last parameter of the production structure is the degree of specialization of operational activities (Achterbergh & Vriens, 2019). This parameter refers to *"the degree to which operational tasks contain only a small part of the complete operational process"* (Achterbergh & Vriens, 2019 p. 59; Kuipers et al., 2018). There is a low degree of specialization if operational tasks cover the complete process. There is a high degree of specialization when the complete operational process is divided into sub-activities and those are allocated to separate tasks (Achterbergh & Vriens, 2019). For example, when a nurse or care staff worker does the washing, dressing and feeding of all the patients, there is a low degree of specialization of operational activities. When there is a high degree of specialization the nurses or care staff workers only take care of one operational activity like washing patients, feeding or dressing patients. This means that only a certain type of employee, who is skilled in these roles, performs particular types of activities (Mohr & Dessers, 2019). Organizations with a high degree of specialization are also called 'functional organizations' (Achterbergh & Vriens, 2019; Mohr & Dessers, 2019). The parameter of specialization is a parameter which is used in a lot of research. In the study of Mintzberg (1983) he refers to it as job specialization and in the study of Smith (1977) it is called division of labor.

2.2.3.2 Control structure

The control structure is about grouping and coupling of regulatory tasks (Achterbergh & Vriens, 2019). For the control structure De Sitter (1994) defined four parameters: the degree of differentiation of regulatory activities into parts, the degree of differentiation of regulatory activities into aspects, the degree of specialization of regulatory activities and the degree of separation. The last parameter is about the relation between the production structure and the control structure (Achterbergh & Vriens, 2019).

The first parameter of the control structure is the differentiation of regulatory activities into parts which consists of three sub-activities: monitoring, assessing and acting (Achterbergh & Vriens, 2019; De Sitter, 1994; Kuipers et al., 2018). The regulatory activities are there to deal with disturbances (Achterbergh & Vriens, 2019). There is a high degree of differentiation of regulatory activities into parts when the activities monitoring, assessing and acting are assigned to different tasks (Achterbergh & Vriens, 2019; De Sitter 1994). When these activities are integrated into one task, then there is a low degree of differentiation of regulatory activities into parts (Achterbergh & Vriens, 2019; De Sitter 1994). In the nursing homes sector a high degree of differentiation of regulatory activities can mean that the manager is responsible for the quality of care that is provided. This could indicate that

managers are responsible for the monitoring and assessing of the quality in the care (Huotari & Havrdová, 2016). In this case the care staff workers were only responsible for the acting part. As described by Achterbergh & Vriens (2019) this means that the three activities are divided and not coupled together. In the study of Verbeek, Zwakhalen, Van Rossum, Kempen & Hamers (2012) an example of low degree of differentiation of regulatory activities was given. In a small-scale nursing home, the care staff workers were responsible for the pace and quality of their work. Which means that the monitoring, assessing and acting were coupled into one task and thus there is a low degree of differentiation of regulatory activities into parts (Achterbergh & Vriens, 2019).

The second parameter of the control structure is the differentiation of regulatory activities into aspects. In organizations there are three aspects of regulation: strategic regulation, regulation by design and operational regulation (Achterbergh & Vriens, 2019; Kuipers et al., 2018). Strategic regulation is about *"setting and resetting goals"* (Achterbergh & Vriens, 2019 p. 60). Regulation by design is about *"designing and redesigning the infrastructure"* (Achterbergh & Vriens, 2019 p. 60). And the last aspect, operational regulation, is about *"dealing with day-to-day disturbances in operational processes given the existing goals and infrastructure"* (Achterbergh & Vriens, 2019 p. 60). There is a high level of differentiation of regulatory activities into aspects when the forms of regulation are assigned to different tasks (Achterbergh & Vriens, 2019; De Sitter, 1994). For example, when the board makes the strategic decisions (strategic regulation), and the operational managers are in charge of the operational regulation. When the degree of differentiation of regulatory activities into aspects is low, this means that the three forms of regulation are assigned to one task (Achterbergh & Vriens, 2019; De Sitter 1994). When a nursing home has a high degree of differentiation of regulatory activities into aspects this could mean that the setting of new goals (strategic regulation), the design of the tasks (regulation by design) and dealing with possible disturbances in the tasks of the care staff workers (operational regulation) is not coupled into one task but done by other employees. With a low degree of differentiation in nursing homes this means that the care staff workers are capable of setting new goals, changing the design of their tasks and dealing with disturbances they face when doing their job (Achterbergh & Vriens, 2019). .

In the control structure there also is a part of specialization, namely the specialization of regulatory tasks. The specialization is about if the employee is involved in the complete regulatory process, or if he is only involved in the product quality and not in the whole process (Achterbergh & Vriens, 2019). There is a high degree of specialization of regulatory activities when the regulatory scope becomes smaller. When the degree of specialization of regulatory activities is low then this means that regulatory tasks have a broader scope in terms of a larger part of the operational process or a larger number of regulators under supervision (Achterbergh & Vriens, 2019). A high degree of specialization in regulatory activities in the nursing home sector could mean that, for example, a manager is only responsible for a small group of employees. This may imply that each small group of

employees has their own superior, who is only capable of dealing with these employees' problems and therefore has a limited scope. This small scope means that the regulation process of the nursing homes is cut into small parts and there are thus many managers responsible for only a small part.

The degree of separation refers to *"the degree to which regulatory and operational activities are assigned to different tasks"* (Achterbergh & Vriens, 2019 p. 61; Kuipers et al., 2018). De Sitter (1994) states that every activity has an operational and regulatory part. With separation the degree to which those aspects are coupled to different tasks (Achterbergh & Vriens, 2019). A high degree of separation means that *"operational tasks contain as few regulatory activities as possible"* (Achterbergh & Vriens, p. 61), whereas a low degree of separation means that the operational tasks have tasks where operational and regulatory activities are integrated (Achterbergh & Vriens, 2019). Organizations with a high degree of separation have activities dedicated to the production structure and activities dedicated to the control structure. This means that the employees on the operational tasks are not connected to the control structure and the other way around. This separation holds for every activity, also for the strategic regulation, regulation by design and operational regulation (Achterbergh & Vriens, 2019). When care staff workers are only delivering care to their residents and are not involved in regulatory activities, this is an example of high separation in nursing homes (Munyisia, Yu & Hailey, 2011). This means that if a disturbance occurs, care staff workers must notify their superior, since they are not obligated to deal with it themselves. With a low degree of separation, the regulatory activities are incorporated in the tasks.

2.2.4 Parameter values

The seven parameters of De Sitter (1994) can have either high or low values. These values have an impact on the essential variables, which is the quality of work in the study of De Sitter (2000). In the next chapter the effect of either low or high values will be discussed. This will be done in two parts, the effect of the values on the production and control structure and in the end on the quality of working life.

2.2.4.1 Effect of parameter values on the production and control structure

The production structure entails the degree of functional concentration, degree of differentiation and degree of specialization (Achterbergh & Vriens, 2019). If structures consist of low functional concentration the structure has semi-autonomous 'parallel production flows' which are assigned to only a subset of orders (Achterbergh & Vriens, 2019). In the figure below there are two independent flows, these flows all have low levels of differentiation of operational activities, this means that production, support and preparation are assigned to one task, as much as possible. Besides the low degree of differentiation there is also a low degree of specialization, because the tasks cover the whole production process (Achterbergh & Vriens, 2019). Low levels of differentiation and specialization

cause broad and rational jobs. These broad jobs cover operational activities relevant to the production of the complete order to be done (Nadler & Tushman, 1997). Because of the involvement in the complete job, employees no longer have small jobs who are only focused on small parts of the process and are divided into functional departments. Now they are part of a semi-autonomous team which performs production, support and preparation (Galbraith, 1973; De Sitter, 1994). They are also responsible for the production of the complete order.

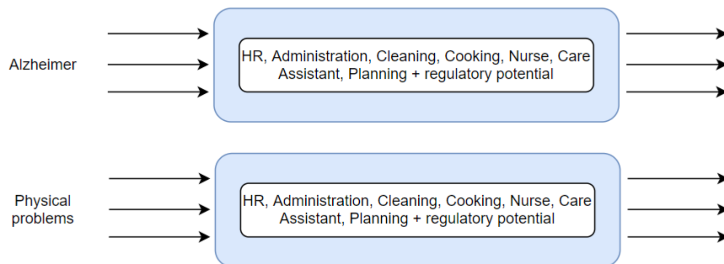

Figure 4: Low parameter values on organisational structure

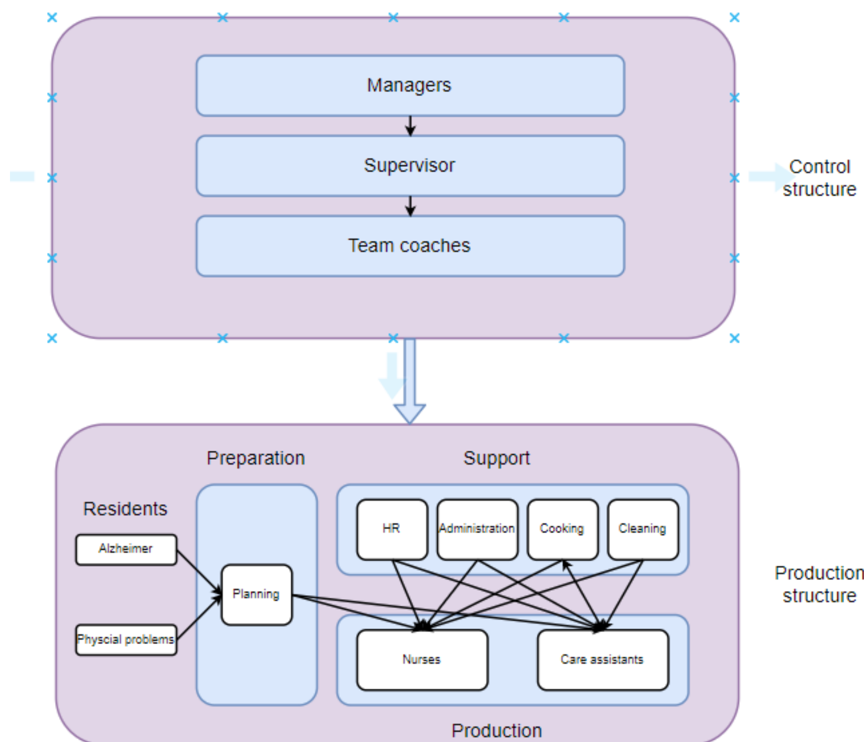

Figure 5: High parameter values on organisational structure

The structure with low values gives the teams regulatory potential for their own product in the flow-related output, because of the low separation. Moreover because of the low degree of differentiation of regulation into parts and aspects these teams are able to perform the whole regulatory cycle of monitoring, assessing and adjusting their own operational activities (Achterbergh & Vriens, 2019). The teams also get the autonomy to improve their jobs by means of relevant changes for realizing the required output (Achterbergh & Vriens, 2019). Besides this regulation by design, there is also space

for strategic regulation which gives them the opportunity to adjust goals which are related to the required output. Teams with low parameter values can be seen as self-contained task groups (Galbraith, 1973; De Sitter, 1994), organic structures (Burns & Stalker, 1961) or as horizontal and agila structures (Anan & Draft, 2007). Low parameter structures form relatively autonomous order flows. The output is then realized by self-contained teams, who have the regulatory potential to completely produce the order output (Achterbergh & Vriens, 2019).

It is not always possible to strive for this maximum low value of parameters. It is context specific how low values can get. The idea behind the theory is to build as low as possible parameter values given the context (Achterbergh & Vriens, 2019). Sometimes it is not possible to create an independent flow because there will be an underutilization, which means that the demand is simply too low to create an independent flow (Achterbergh & Vriens, 2019). Also, for the control structure it is sometimes not possible to reach the lowest possible parameter value. Tasks can get too complex and broad when adding to many regulatory parts (Achterbergh & Vriens, 2019). The recommendation of De Sitter is *"build structures with parameter values that are as low as possible, given the specific organizational and market conditions"* (Achterbergh & Vriens, 2019 p. 86). When a company has a high degree of functional concentration and differentiation this leads to an increase of quality of working life (Achterbergh & Vriens, 2019). With a high degree of functional concentration there is a high level of variability. Variability means that there are lots of order types, which eventually results in a higher chance of disturbances (Achterbergh & Vriens, 2019). Because of the high degree of specialization and differentiation the amount of relation is increasing, because they are dependent on each other. A high number of relations causes a higher probability of disturbances because they need to interact with each other and they are dependent on each other (Achterbergh & Vriens, 2019; De Sitter, 1994).

2.2.4.2 Impact of values on quality of working life

To reach the quality of work variables the structure of an organization should have as low as possible values on the parameters. As mentioned before, the quality of work from De Sitter (1994) consists of three parts namely: degree to which employees can learn and develop while doing their jobs, degree to which they feel involved, both socially and intrinsically and degree to which they experience job-related stress (Achterbergh & Vriens, 2019). These criteria of quality of work can be linked to the Job Demand model of Karasek (1979) as mentioned before in this chapter. Structures with low value on the parameters offer better opportunities for individual learning than structures with high values. These low parameter structures make it possible to work in broad, rational tasks that cover the whole production process. Besides this with these tasks they have the regulatory potential to detect possible faults in the primary process and to take care of these faults (Achterbergh & Vriens, 2019). Low parameter values support the learning cycle of problem detection and the correction of these problems (Morgan, 1986; Anand & Daft, 2007). Low parameter values not only cause learning with regard to

the primary process and the operation regulation. It also causes opportunities for learning about the organisational goals, and the adjustment of those goals, by means of strategic regulation (Achterbergh & Vriens, 2019). It contains single loop learning, which is connected to learning with regard to the primary processes and double loop learning which is connected to goal setting and adjusting (Argyris & Schön, 1978). So low parameter values give the employees the opportunity to change their tasks when there are errors by the regulation by design, gives them the opportunity to learn and detect problems by means of the operational regulation and gives them the opportunity to set and reset goals by means of the strategic regulation (Achterbergh & Vriens, 2019). When in a nursing home the care staff workers are coupled to all the resident types, there is a high degree of differentiation (Mohr & Dessers, 2019). A high degree of differentiation causes complexity and possible disturbances. These disturbances have a negative impact on the quality of work (Achterbergh & Vriens, 2019). In nursing homes there is a high level of separation between the production structure and control structure (Munyisia, Yu & Hailey, 2011). This high degree of separation causes a lower regulatory capacity (Achterbergh & Vriens, 2019). When the regulatory capacity is low and the disturbances are high, this has a negative impact on the quality of work (Achterbergh & Vriens, 2019; De Sitter, 1994).

2.3 COVID-19 crisis situation

COVID-19 was declared a pandemic by the World Health Organization in March 2020 (WHO, 2020). This pandemic can be seen as a crisis situation. There are many different definitions of a crisis situation (Valackiene, Virbickaité, 2011; Allen & Caillouet, 1994; Coombs, 2015; Weick, 1988). The COVID-19 pandemic is also called a public health crisis. In the study of Boin & 't hart (2007) there are three components namely, uncertainty, urgency and threat. In the corona crisis there is a lot of uncertainty. It is not possible to predict how the virus will spread (Brinks & Ilbert, 2020). The second component is urgency. In this pandemic there is no time to stand still and wait for something to happen. It is urgent to take measures and prevent the virus from spreading (Brinks & Ilbert, 2020). The last component is about threats. The pandemic threatens our public health (Dong & Bouey, 2020) and the nursing homes are one of the places where there are the most deaths (Barnett & Grabowski, 2020). Besides the threats to public health, also the economy is under enormous pressure (Brinks & Ilbert, 2020). Due to the COVID-19 virus the population is facing a public health crisis (Dong & Bouey, 2020). This crisis situation, also called the corona crisis, has an impact on the care staff workers. To prevent the spreading of the virus measures should be taken. These measures have a negative impact on the quality of work of the care staff workers (Lucchini et al., 2020; Giuliani et al., 2018). Besides these measures, the care staff workers also do not want to infect the residents, which again have a negative impact on the quality of work (White et al., 2021). Because of the crisis situation things are dealt with in a different way. The crisis situation has an impact on the quality of work and is thus important to consider in the research.

Organizations can choose to redesign their organisational structure in times of crisis, for example to centralize coordination. To stop the corona crisis, the Dutch Government centralized coordination (Moorkamp, Torenvliet & Kramer 2020; Janssen & Van der Voort, 2020), an example of this is the National Coordination Center for Patient Distribution (LCPS) which coordinates the moving of COVID-19 patients from overcrowded hospitals to hospitals who still have spots left (Moorkamp et al., 2020). An example for the care sector could be that they develop a centralised workgroup who decides what the policy in the organization would be. Such a centralisation causes a high degree of separation, because the operational tasks are separated from the control tasks (Achterbergh & Vriens, 2019). In order to stop the rising number of COVID-19 cases the government is also taking measures. Rising infections means that the pressure on the hospitals will increase, intensive care will become overcrowded, and the hospitals can't meet the demand (Moorkamp et al., 2020). The National Institute for Public Health and the Environment (RIVM) is continuously monitoring the outbreak in The Netherlands. In combination with the Outbreak Management Team (OMT), which consists of multiple specialists in the care sector, they give advice to the Dutch Government. To prevent the spreading of the virus the Dutch Government came up with an 'intelligent lockdown'. This means that the catering industries, pubs and other not necessary shops are closed. Besides these measures there is also a limit on visitors in your own home, working from home as much as possible, keeping 1.5-meter distance and wearing a facemask in public areas (Wallenburg & Helderman, 2020). In this study a crisis situation will be defined by the study of Boin & 't Hart (2007).

In March 2020, the Dutch government placed nursing homes under quarantine to prevent the virus from spreading (Kruse, Abma & Jeurissen, 2020). In nursing homes there live different types of residents, so also residents with dementia. For them it is tough to understand the quarantine and they need more attention and extra restriction measures which could lead to aggression (Gerritsen & Oude Voshaar, 2020). This quarantine led to a social isolation for the residents because there was a visit ban and activities were cancelled (Verbeek, Gerritsen, Backhaus, De Boer, Koopmans & Hamers, 2020). After a while of isolation care staff workers saw that the residents showed mental depletion (Van der Roest et al., 2020). The depletion of the residents has an emotional impact on the care staff workers (Armitage & Nellums, 2020; Fischer et al., 2020). An alternative for the social isolation in the nursing homes is video calling (Van der Roest et al., 2020). It can be expected that because of the lockdown there is less support from other disciplines. This means that the care staff workers could need to do additional tasks like cleaning and delivering food to the residents. This causes a change in the organisational structure, because then the support activities become part of the production structure. These additional tasks lead to an increased workload (Kusmaul, Perry & Halvorsen et al., 2020).

A shortage of employees was already a problem in the nursing homes, but because of COVID-19 this even became a bigger problem. Employees are sometimes unable to go to work because they are

infected, or employees are not willing to work under such circumstances (Grabowski & Mor, 2020). Without the proper measures the staff could infect each other or residents who then infect staff (Grabowski & Mor, 2020). When the employees are unable to come to work, the shortage of staff becomes even a bigger problem. The care staff workers are afraid of taking COVID-19 home to their families (Kusmaul et al., 2020). Another problem for the care staff workers was the additional tasks that COVID-19 brought with them. Before COVID-19 they already had too many tasks, but this dramatically increased because of COVID-19 (Kusmaul et al., 2020). Because of the extra tasks and the time pressure, nursing homes could scale down the care of the residents (Kuwahare, Kuroda & Fukuda, 2020). Scaling down care could mean a change in the production structure, that care staff workers do not perform certain activities like washing or cleaning anymore (Achterbergh & Vriens, 2019).

Chapter 3 Methodology

In the methodology chapter the research methods and strategy will be discussed. The first part is about the research strategy. After that there will be discussion on how the data is collected, how the concepts are measured and who is interviewed. After this step the interview questions will be discussed. At the end of the chapter there will be discussed how the data will be coded and how the quality of the research and ethics are ensured.

3.1 Research design

In this research the philosophical perspective is interpretivism. The point of view is that the researcher can only gain insight and understand the perceived quality of working life of the care staff workers by accessing and understanding the meaning and interpretations of care staff workers to outline the behavior by looking at how they experience, articulate and share with others (Symon & Cassell, 2012; Guba and Lincoln, 1994; Myers, 2009; Corley & Gioia, 2004). This philosophical perspective puts the meaning and perception of the respondent and the researcher central in this study (Symon & Cassell, 2012).

In researching the perceived quality of working life and the impact of the organisational structure on the perceived quality of working life, rich data is needed. That is why this study is of a qualitative nature. In the introduction and theoretical framework, there has been shown that research has been done concerning the linkage of perceived quality of working life and organisational structure. Given the COVID-19 pandemic the context of the research is different from other research and thus very important to understand the perceived quality of working life in this crisis situation. It's crucial to learn how care workers themselves assess the quality of working life. Especially when this is about emotional behavior, then you need rich data to gain insight in how they perceive quality of working

life and how the organisational structure is related to the perceived quality of working life. Qualitative research is most suitable for this since qualitative research gains rich data of social phenomena (Bleijenbergh, 2015; Myers, 2009). Besides this it is important to understand the context to see how the perceived quality of working life is during the COVID-19 pandemic. Understanding this and being able to dive deeper into this context gives the opportunity to understand the social and cultural contexts in which those employees live (Myers, 2009). Another advantage of qualitative research is that it allows the researcher to observe and grasp the context in which the respondent views the phenomenon (Myers, 2009).

This research will be abductive in character. The research is constantly moving back and forth between the data and the theory when doing abductive research (Gioia, Corley & Hamilton, 2013; Dubois & Gadde, 2002). An abductive approach is in between inductive and deductive approach. Instead of going bottom-up, as in an inductive approach, you also want to include theories at the beginning of the research to look at underexposed concepts of the literature, in this study the Job Demand Control model of Karasek, and to be able to contribute to this theory (Dubois & Gadde, 2002). As a result, unlike deductive research, abductive research focuses on constructing concepts rather than verifying existing theories (Dubois & Gadde, 2002). In paragraph 2 a broad theoretical framework is built. The findings will not be focused solely on the theories used. The theories will be used as guidelines for the data collection and the data analysis process (Dubois & Gadde, 20020). By analysing the theories, sensitizing concepts are formulated which give a better and more broad understanding of quality of working life and thus give guidance to the interviews and data collection (Timmermans & Tavory, 2012). So, by researching the Job Demand Control model of Karasek (1979), the researcher looks to see if concepts of the existing literature are underexposed and need to be revised or that the model needs to be elaborated.

In this study the researcher will research two nursing homes of one organization. Both nursing homes have the same organisational structure and job designs before COVID-19. One nursing home will be selected with the criteria of relatively low COVID-19 infections and the other nursing home with relatively high COVID-19 infections. The difference between these two nursing homes will be researched, this makes it a comparison study (Myers, 2009). By researching two locations with the same organisational structure, the effect of COVID-19 can be seen better. The foundation of the two locations is the same, so in this way they can be compared to each other and see if there are differences. The organisation is located in an eastern part of The Netherlands and has 13 nursing homes. In these nursing homes 182 care staff workers. In total the organisation counts 2559 employees. As mentioned in the introduction and theoretical part, the study will investigate the quality of working life during the corona crisis. This puts the context of the study in another context, namely a crisis situation.

3.2 Data collection

Interviews are performed and documents are analysed for this research. By combining those two types of data collection, there is method triangulation which makes it possible to get a full understanding of the quality of working life of care staff workers and the organisational structure of the organisation (Bleijenbergh, 2015; Myers, 2009; Klassen, Creswell, Clark, Smith & Meissner, 2012). Regarding the interviews, these are semi-structured interviews with open-ended questions. By doing semi-structured interviews the researcher can give guidance to the interviews by setting up predefined questions, but there is also space to gain new insights when new topics arise in the interview (Bleijenbergh, 2015; Myers, 2009). The predefined questions are based on the concepts of the theories discussed in paragraph two. The concepts discussed in the interviews will be job demands, job control and the organisational structures of De Sitter (1994). By using these concepts, the researcher gives guidance to the interview and makes predefined questions to examine the perceived quality of working life and the organisational structure in the nursing homes.

There are 13 interviews conducted in total, with a total of 14 respondents. These 14 respondents are divided over two nursing homes, so there will be 7 respondents of each nursing home. After conducting the interviews, they will be transcribed. The transcripts are sent to the respondents to check whether the researcher understood and transcribed them correctly. The duration of the interviews was between 40 minutes and 70 minutes. Six of those interviews were with care staff workers and the last interview was with the managers of both locations. This manager is the expert when it comes to the structure in the organisation. The interviews are conducted with care workers and nurses who have direct contact with the residents. They also face the challenge of not infecting their patients and their family members, that is why interviews with only care workers and nurses who are in direct contact with the patient are chosen. During the interviews, the focus was mostly on the perceived quality of working life and how their tasks influence the perceived quality of working life. To get in contact with the organization, I contacted my sister who is working for the organization with the question if she can put my question through to her manager. Via e-mail I wrote a request to gain access to the organization, which you can find in appendix 2. The request was accepted, and I had an appointment with the RVE manager of the organization to discuss the research and the necessary parts and input. Since this study is a comparison study, two cases should be selected. In the conversation I gave my criteria, and the organization selected appropriate cases for the study. Via this way I got access and the RVE manager asked team coaches of each nursing home to arrange 6 possible respondents. So, the respondents are selected by the nursing home itself and they gave me the personal information of the care staff workers so I could contact them with the question if they wanted to participate in my research.

Besides interviews, there are documents analysed from the organisation like an organogram, employee satisfaction survey and the job description of the care staff workers. The employee satisfaction survey was held during the COVID-19 pandemic and is also focused on the topic of COVID-19. These documents gave insights into the organisational structure of the organisation. These documents can be a complement to the interviews (Bleijenbergh, 2015) which are conducted. By analysing the documents, the researcher can gain insight in how the job is organised and thus ask specific questions about their tasks. Documents provide less risk because respondents do not give socially desirable replies, which is a complement to the interviews (Myers, 2009), they give a precise view of how the jobs are organised (Bleijenbergh, 2015). For this study 5 documents are collected, one organogram, one employee satisfaction survey and three job profiles of different types of care staff workers. By analysing these documents, the research can gain good insight in how the organisation is structured and how the jobs are designed.

Because of the coronavirus the interviews cannot be held face-to-face. There are strict measures in The Netherlands, and it is thus not possible to conduct physical interviews. So, the interviews are held online via video or telephone conversations. Doing an interview via video makes it more difficult to read the body language of the respondent and to see some nonverbal communication (Deakin & Wakefield, 2014). When conducting an interview via telephone it is even impossible to see the body language of the respondent. The body language of the respondent is important in understanding their story (Deakin & Wakefield, 2014; Weller, 2017). Doing the interviews via video does not only have disadvantages, but it also makes it easier to schedule an interview, gives the feeling of a less formal setting and the costs will be lower because of no transportation costs and time (Deakin & Wakefield; Weller, 2017). The interviews via video or telephone are recorded, so they can be transcribed afterwards. An overview of the interviews with the care staff workers is presented in a table below, which includes the source of the interview, title of the respondent and the number of words used in the narrative story.

Responden	Job	Gender	Location COVID cases	Source Used	Number of words
1	Nurse	Women	High	Phone	1680
2	Care worker	Women	High	Phone	710
3	Nurse	Men	High	Zoom	2324
4	Care worker	Women	High	Face to Face	814
5	Care worker	Women	High	Face to Face	535
6	Nurse	Women	High	Face to Face	983
7	Manager	Women	High	Zoom	Not asked
8	Care worker	Women	Low	Phone	567
9	Care worker	Women	Low	Phone	86
10	Care worker	Women	Low	Phone	454
11	Care worker	Women	Low	Zoom	769
12	Care worker	Women	Low	Phone	483
13	Care worker	Women	Low	Phone	115
14	Manager	Men	Low	Phone	Not asked

Figure 6: Respondents

3.3 Sensitizing Concepts

The literature described in paragraph two is used to formulate sensitizing concepts. Sensitizing concepts can be seen as a guidance concept in a general form to guide the data collection and the coding process (Bleijenbergh, 2015). In the literature two concepts are distinguished namely, quality of working life and organisational structure. The sensitizing concepts for quality of working life will be job control, job demand and social support. Job demand can be seen as the stressors in the jobs of the care staff workers. Job control will be seen as the way how care staff workers can control their job demands. It consists of two types, job decision authority and skill discretion. Job decision authority is about making their own choices and consists of two types namely, the authority and autonomy of the care staff workers. Job skill discretion will be seen as the amount of skill and knowledge which can be applied by the care staff workers. Social support will be seen as the support from friends, family and co-workers or managers. The second concept is about the organisational structure. The sensitizing concepts for the organisational structure are the degree of functional concentration, the degree of differentiation of organisational activities, the degree of specialisation of organisational activities, level of separation between production structure and control structure, the degree of differentiation of regulatory activities into aspects, the degree of differentiation of regulatory activities into parts and the degree of specialisation of regulatory activities.

3.4 Data analysis

In order to get to the findings and to build a data structure, the interviews and documents are coded. The data analysis method used in this research is the Gioia method, because there is a continuous movement between the data and the theory. The Gioia method is appropriate for this type of research (Langley & Abdallah, 2011; Corley & Gioia, 2004). The philosophical assumption used is the interpretivist, since this is also the most appropriate epistemological assumption for the Gioia method (Langley & Abdallah, 2011), it can be concluded that the Gioia method fits well in this research. In the Gioia method code levels are strict. It distinguishes three code levels namely, first order codes, second order codes and third order codes (Corley & Gioia, 2004; Langley & Abdallah). The coding process has several steps, from first order codes to third order codes. The coding will get more abstract after each step (Bleijenbergh, 2015; Myers, 2009). The first level of coding is the first order codes. In the first order codes fragments are taken from the transcript text and the researcher tried to stick as close as possible to the original phrasing of the respondent (Bleijenbergh, 2015; Myers, 2009; Corley & Gioia, 2004; Langley & Abdallah, 2011). The next step are the second order codes. The first order codes are researched to look for similarities between the first order codes and group them together in higher order themes (Bleijenbergh, 2015; Myers, 2009; Corley & Gioia, 2004; Langley & Abdallah, 2011). In the last step the second order codes are compared to look for overarching theoretical dimensions, third order codes (Bleijenbergh, 2015; Myers, 2009; Corley & Gioia, 2004;

Langley & Abdallah, 2011). The data structure is formed by the last code level, third order codes, shows how the data gathered and the theory are coupled together, this forms the final data structure (Gioia et al., 2013; Langley & Abdallah, 2011). For the code structure, see figure 6. A more expanded version of the data structure can be found in appendix 3.

1st order	2nd order codes	3rd order
Extra tasks causing to scale down care	Scaling down care	Changes because of COVID
Looking which care can be scaled down		
Tough feeling about scaling down care		
Isolationg part A and part B to prevent COVID spreading	Measures to prevent spreading	
One employee visited the COVID patient through the day		
Trying to put COVID patient into one route		
Three COVID cases in the location	COVID infections residents	
Positive COVID case in quaranteen		
Sign on the door to show that COVID is there		
Infected colleagues cannot work	COVID infection colleagues	
Less employees because of COVID infection		
Most of the colleagues are infected with COVID-19		
C&C is more needed because of COVID	Decision during COVID	
CCT make COVID policy		
Only RVE managers in CCT		
All types of residents are mixed up in the location which causes complexity	Resident structure	Organisational structure
Care workers see other residents every day		
The residents are not divided on the basis of the care they need		
C&C makes decisions when nobody else does	Decision structure	
Coordinating their own tasks		
Coordination of tasks done within the team		
COVID policy changes needs to be discussed with C&C		
Doing the dished and cleaning the toilet	Task structure	
Influence on the recruitment process		
More alert for small complaints		
Nurses and care workers perform the same tasks		
Nurses level 4 and nurses level 5 have more authorizations		
Planning is part of every care team		
Tasks within team roles in a self organising team		
Nice day worker is there for the extra attention of the residents	Team structure	
Planning is part of every care team		
Team in charge of budget, planning and room occupancy		
Team planners plan the routes		
Three different skilled types of care worker in oen team		
Feeling supported by their family	Family support	Social support
Support from family and friends during the positive COVID period		
Talking with sister who also work in the care sector		
Demotivated because family break the rules	Negative contact residents family	
Negative contact with family is time consuming		
On a poiint feeling more a cop than care worker		
Peacefull that the family was not around		
Threatened by residents family		
Colleagues giving strength	Peers support	
Strong team		
Supporting their colleagues		
Working in a team which give strength to go to work		
Colleague most important reason for nice work environment		
Appreciation makes her proud	Patient/family support	
Feeling supported by the residents family		
Seeing the residents and residents family happy gives strength		
Good communication is important for nice work environment (could be better)	Communication	
Fast changing policies		
Inconsistent policy of the organisation		
No clear guidelines		
Not giving answers causes stress		
Gray areas, not much known about COVID	Uncertainty	Job demands
Not knowing what is going to happen		
Unable to get grip on the COVID spreading		
Uncertainty causes stress		
Working while not knowing what to do		
Less relaxation because of restrictions in private life	Private balans	
Take work to home		
Taking work home		
Tough private balance		
Facemasks are a bit of nonsense	Working with measures	
Headache and thirst because of wearing face masks		
It was stuffy with the facemasks when showering the residents		
Not looking forward to wear the suit		
Tough work conditions with protection materials		
Food delivery as extra task	Time pressure	
Hard because you do not have the time to visit the resident because of the extra tasks		
Less employees because of COVID infection		
Lockdown causes extra jobs for the carestaff workers		
Taking over the tasks of the residents family		
Most common reason for workload is getting enough people on the workfloor		
Afraid of infection others	Emotional exhaustion	
Infected her husband		
Not afraid of getting infected		
Emotional exhaustion to see the residents depletion		
Painfull to see the residents lonelyness		
Demotivated because family break the rules	Violation of the rules	
Not nice to correct the family for not following the rules		
On a poiint feeling more a cop than care worker		
Security to correct the families		
Delivering the right care	Quality of care	
Not being able to deliver the right care		
Second reason for workload is not enough time for the resident		
Frustrating to not be able to organise events for the residents	Decision authority	Job control
No control about the lonelyness of residents		
Able to make own decissions during COVID		
Dividing tasks continuously		
Influence on the recruitment process		
More autonomy now COVID is fading away		
Policy changes needs to be discussed with C&C		
There was no choice		

Figure 7: Code structure

The coding process is done with the ATLAS.ti software. The ATLAS.ti is appropriate to analyse interviews, documents and other forms of empirical material (Bleijenbergh, 2015). Besides this it also allows me to save memos of the coding process and possible methodology changes made during this research (Bleijenbergh, 2015). By using a computer driven coding program, it is possible to analyse large amounts of data (Yin, 2014). Another advantage of using computer drive data programs is that the usage of a certain coding format makes it easier to trace for other researchers (Bleijenbergh, 2015). Using coding programs makes it easier to group different texts from different interviews together when they have the same coding (Bleijenbergh, 2015).

3.5 Quality of research & Ethics

In the literature there is a distinction between quality criteria based on your philosophical assumptions. This study will be an interpretivist study, so I take a look at the criteria for interpretivism. To assess the quality criteria, from an interpretivist assumption, Symon & Cassell (2012) described four pillars namely, credibility, transferability, dependability and confirmability.

According to Symon & Cassell (2012) credibility refers to the fit between the constructed reality of the respondent and the constructed reality of the researcher. I noted my constructed reality in order to see if the respondents have changed my view by providing information during the interviews. Quality criteria transferability is about the description of the research case (Symon & Cassell, 2012). The researcher should provide enough context so the reader can judge if the outcomes are applicable in other contexts as well (Symon & Cassell, 2012). I ensured the transferability by providing a detailed description of the context in the introduction and theoretical framework. To make it even more detailed I provided a detailed description of the case studied in the methodology part. Dependability is about the changes the researcher made in the research (Symon & Cassell, 2012). By using memos, in which I note the changes in my research and the reason behind the changes, the dependability is ensured. The last criteria is confirmability which is about how you gathered the data and how this data is transformed into the findings (Symon & Cassell, 2012). I ensured confirmability by providing the predefined question, because of the semi-structured nature of the interviews. So, it can be seen which question is asked during the interview. Besides this the code structure and reasoning behind this code structure is discussed in the methodology section. Every step of the coding process is discussed, and the coding level and examples is shown.

In this research there are some measures taken to ensure ethics while conducting this research. Honesty is perhaps the most fundamental part of ethics (Myers, 2009). In the book of Myers (2009) several measures are formulated to ensure ethics in a research, below is explained how the ethics are ensured in this research. To ensure honesty in this research, the organisation which is researched is informed about every step that is taken in the research. I told them what the research is about, which

data is collected and how and where the data will be used for. I assured them from the fact that all the data gathered in this study is only used for research purposes and that the organisation and the employees stay anonymous. Besides this the respondents are told that the interview will be recorded and transcribed and that they at all times can access these transcripts. The transcripts are emailed to the respondents once the interview is completed, giving them the opportunity to review them and cut out any parts that they are uncomfortable with. It is clearly stated that the transcript will only be forwarded to the supervisor. The respondents are informed that they are not compelled to participate in the interviews. This is important for informed consent, which means that they will "*be enabled freely to give their informed consent to participate and advised that they can terminate their involvement for any reason, at any time*" (Payne & Payne, 2004 p. 68). Another important part of informed consent is having permission from an appropriate manager (Myers, 2009), in this study this is the case since the RVE manager, and the team coaches give me permission to conduct the research in their organisation. So, before the interviews were conducted, I asked the respondents for their informed consent. To ensure the ethics in this research I signed the Research Integrity form of the Radboud University, which can be found in appendix 4.

3.6 Timeline

The timeline will give an overview of how the research will be scheduled and how long every step in the research will take. This is displayed in a GANTT-chart. The process of conducting, transcribing and analysing the interviews will have a parallel timing. By doing this I'm able to see if the interview guide is suitable and if I have to make certain changes. Also, interesting findings from previous interviews can be included in the next interviews to check whether this is relevant.

Subject	Duration days	Start	End
Introduction	8	18-jan	26-jan
Theoretical framework	24	26-jan	19-feb
Methodology	19	19-feb	10-mrt
Finishing proposal	16	10-mrt	26-mrt
Data collection			
Interviews	28	19-apr	17-mei
Transcribe	28	19-apr	24-mei
Coding	7	19-apr	31-mei
Findings	7	31-mei	7-jun
Conclusion	4	7-jun	11-jun
Finishing MT	3	11-jun	14-jun
Defence			

(Chart columns: Week 3 – Week 24, each with days S M T W T F S)

Chapter 4 Results

In this chapter the outcomes of the concepts of quality of working life and the organisational structure will be discussed. From the collected data and the theory of Karasek three concepts for quality of working life could be aggregated. The concepts are job demands, job control and social support. Besides these concepts, two other concepts are aggregated. One concept about the organisational structure and one concept which points out the organisational structure changes because of COVID-19. From the data it became clear that not every concept was applicable on both cases, that is why also the counter argument will be discussed, when necessary. First the organisational structure will be discussed and after that the concept of quality of working life.

4.1 Organisational structure

The concept of organisational structure points out how the organisation is structured in the locations. In terms of the organizational structure before and during COVID-19. The organisational structure was the same in both cases.

4.1.1 Structure before COVID-19

The teams consist of 8 to 12 employees and are composed of three different types of employee levels namely, care worker, nurse level 4 and nurse level 5. When it comes to giving care, the employees in the care team do the same tasks. Besides these tasks the nurses of level 4 have additional tasks, and the nurses of level 5 can give indications to the residents. In the teams there are team roles which are divided among the employees in the team. There are 4 roles namely, business operations, quality, employee and client. These roles are filled by employees, but not divided over all the employees, only one is responsible for one role. Within these roles there are wide frames. Examples of tasks are the ability to make their own planning, own budget and they are responsible for the room occupancy of their department. The idea of the organisation is to work with self organising teams, by giving them the 4 team roles which can be divided. Besides these team roles, the team is also responsible for the recruitment process. The planning is part of the tasks of the care team, which makes it a medium degree of differentiation of operational activities, because a support task, planning, is added to their tasks.

> *"So, if you have the role or task employee, for example, there are two employees in the team who ensure that if there is a formation space that the vacancy is posted. For example, they did that very much in the beginning when I came they did the application interviews themselves, I thought they lacked some quality. So euhm .. we now often do all the conversations euhm .. together. And if there is still any*

> *doubt, we will then have a click conversation with two employees about someone really fitting into the team, so they do have an influence on who comes into their team, for example."* (Respondent 7, Women, Manager, Location with high COVID-19 infections).

The tasks that the care workers and nurses perform are the same when they are in the resident route. They perform all the tasks necessary for the resident. Providing all the activities means that there is a low degree of specialization of operational activities, because they perform all the tasks and not just a part of it.

> *"No, no, that is also new to me. Here they really only have caring IGers and a number of nurses, but mainly caring IG and no helping. That was also new to me, so. In such a route, the caregiver IG simply does everything. When he is with a client, he gets them out of bed, washes him, gets dressed, makes a sandwich, empties the bag from the trash can. So that actually does the whole picture.'* (Respondent 14, Men, Manager, Location with low COVID-19 infections).

Looking at the tasks which the care workers and nurses perform, the typical tasks are washing, dressing, showering and making food.

> *"Washing, dressing, showering, preparing food, sharing medicines, well that mainly, putting on stockings, putting people to bed, getting people out of bed. Those are the main tasks."* (Respondent 14, Men, Manager, Location with low COVID-19 infections).

Every team has a coordinating nurse, who coaches the team and gives guidance, the nurse is part of the care team. Besides the employees who take care of the residents, there are also nice day workers (medewerker mooie dag). The nice day workers are concerned with social activities with the residents. They do not perform any nurturing actions.

In both locations the care is complex because there are different resident groups. To begin with, rental residents who don't get any care and the location are not responsible for them. The second type is the resident with a homecare indication and the last type is the resident with a nursing home indication. These residents are not grouped together in the location but spread all over the place which causes complexity for the care workers and nurses. The different types of residents should be treated differently because of laws and regulations around their indication. This indicates that there is a high level of functional concentration since the care workers and nurses are coupled to all the resident groups, and not just one group.

> *"Yes you know this is very complicated. The organization has chosen to allow the houses to exist as residential care centers. In principle, this concept has not existed for years. But they chose to leave it here. Which is very nice, because it is very future-oriented because you have a lot of types of care in one residential care center which is located in a neighborhood, so that it remains very accessible for everyone and so you do not have to move 100 times, but rather within the different locations. types of care, so also client friendly. Only the choice was made to do it very spotty, so I'll just name something at number 50 lives a neighborhood client and at 51 there is a nursing home client and because it is so criss crossed together, you have to imagine that Pietje is a nurse and he is now going to 50, the quality framework has to be set up, say from the district care, and at 51 it has to set up the quality framework nursing home care. So of course, it also depends on what indication you have of which actions you can and cannot do and what funding is behind it. Look, that is of course very confusing if you have 6 or 7 clients on a morning that then all the time, or at least three nursing home clients and the rest of the neighborhood clients that is all mixed up. That is very confusing and that makes it complex."* (Respondent 14, Men, Manager, Location with low COVID-19 infections).

Respondent 7 (Manager, Women, Location with high COVID-19 infections) agrees with this since the structure is very confusing for the care workers and nurses, but also for the residents.

> *"And that makes it very complicated because it is actually in 2009 that it would be abolished. We have not quite sorted that out yet. And that is our next step. Because just uhm .. to make it clearer because sometimes you become there, an employee or a resident says then also in the grand cafe of yes they put the laundry in the cupboard, but they do not do that well with me. They always leave it in bed there. And then you have something to explain again that it depends on the indications, and you also have that with family members but also with care workers yes .. Ooh, I don't know who I should or should not do that anymore. I'll just put it in the closet. Yes it does take time. And that goes away from other things."* (Respondent 7, Women, Manager, Location with high COVID-19 infections).

This type of care was abolished in 2009, but this organisation is still working with the old system. Not only the different resident groups are mixed up, but also the types of indications within a certain resident group. Residents with dementia are not coupled together. When nurses perform a route, they see not only residents with dementia or physical problems, but all together. This indicates that there is

a high level of functional concentration since the care workers and nurses are coupled to all the resident groups, and not just one group.

> *"Everything is intertwined here. We have home care customers here, and we have WLZ residents here with treatment and we have WLZ residents here without treatment and actually there is a mix up here in a route which, by the way, is not my preference, but that is what has been said here so far. hand."* (Respondent 14, Men, Manager, Location with low COVID-19 infections).

The residents are divided into routes. Every care worker or nurse walks the route and handles all the residents who are put into that route. These routes are composed by the care team themselves. They have the ability to design the route. And the nurses make 'cards' with the indication of the resident. After that the planners of the care team compose the route.

> "*Yes, those routes are also planned by the planners. You must, you have the authority to create route maps. The nurses do that, they produce those cards. And the planners plan the routes based on the services."* (Respondent 14, Men, Manager, Location with low COVID-19 infections).

The routes within the location are divided between the care teams in the location. The care workers and nurses have short shifts, day shift, evening shifts and night shifts. Every shift has its own timeslot.

> "*Well, you say in the morning we start with 12 routes, and you then have 4 day shifts, so we have 4 teams, so each team has 1 day shift from 07.00-15.30 and then each team also has 2 short morning shifts from 07.00- 10.30. And each team has a late shift, so it starts at 15.15 to 23.15 and one person has a night shift. And those routes are just completely full, anyway the routes in the morning are full of people washing, dressing, medication, breakfast, that sort of thing. And do you have a break and then you go back to share medication, eye drops, pick people up for the grand cafe, go downstairs like that noh and then you have a half hour break in the afternoon and then like now you have another round needing to take medication again, or check-ups."* (Respondent 11, Women, Care worker, Location with low COVID-19 infections).

The care workers and nurses are not responsible for one route. They do the same route sometimes, but there is also variety. *"We have the ground floor, first, second and third floors, the workforce changes during the week. We do see different people, so you see that the same people always see the same people, no not that."* (Respondent 3, Men, Nurse, Location with high COVID-19 infections).

Every resident in the location has its own apartment. This means that the care is held in a homelike environment. The care workers and nurses experience this as a very nice way of working. *"Yes, nice. Yes I mean the people here live in their own house and have their own things so they will yes I think that is very pleasant yes."* (Respondent 4, Women, Care worker, Location with high COVID-19 infections). Most of the care workers and nurses have a greater connection with the residents because of the homelike environment in which they provide care. *"Yes, yes I think. You will meet someone in your own environment, right. Yes and it will, yes. I think that gives more connection."* (Respondent 10, Women, Care worker, Location with low COVID-19 infections). A nurse states that this type of care makes it more possible to spot signals of possible depletion. When someone does not clean up his bed for example.

> *"I think it will become visible faster, the moment you yourself change a lot in your homely atmosphere. But once you don't make your bed, you have too little laundry, you drink and eat a little less than you normally do. I think that in view of that in terms of household, we do notice a lot."* (Respondent 3, Men, Nurse, Location with high COVID-19 infections).

Every location of the organisation has its own coach coordinator, also called the manager. The coach coordinator is responsible for the care teams within the location. When there is a need for guidance or the care team is not able to deal with things, then the coach coordinator will be consulted. The coach coordinator falls under the results unity of responsibility (RVE) manager. The organisation is divided into two departments namely residential care center and the homecare. Every department has its own RVE manager. And the RVE manager falls under the board of directors (Organogram). In the layer of the RVE manager they monitor the results within the location. They have short lines with the coach coordinators within the location to be able to adjust the results when they are not good. When it comes to operational activities which fit within the policy of the organisation, the care team can take their own decisions, but when there is a policy change they want to make they need to discuss this with the coach coordinator. Looking at the parameter values, there is a high degree of separation between the production structure and the control structure since the care workers and nurses have the ability to change operational activities, but not the ability to make strategic or policy changes.

> *"I think that when it comes to changing policy, I think they should discuss this with me first. Then it is something very operational that fits within the policy. I know a lot we use, call something simple uhm then I think that care professionals themselves know how to do it best, so you have to decide for yourself. When it comes to protocols, guidelines and policy, for example the corona policy that is organization wide. Then I don't think they can make a decision about it themselves*

without discussing it with me." (Respondent 14, Men, Manager, Location with low COVID-19 infections).

In order to understand the structure better, it has been visualized (figure 9). The organisational structure was exactly the same for both cases, that is why there is one visualization which applies for both the cases. What can be seen is that there is a high level of functional concentration, because the different types of resident and indications are not clustered together, and the care workers and nurses visit all the types. Looking at the teamwork, the planning, HR, Admin and care are in the team. This means that there is a medium degree of differentiation of operational activities because the preparation activities are within the team (planning), but support activities like cleaning and cooking are not tasks of the care team.

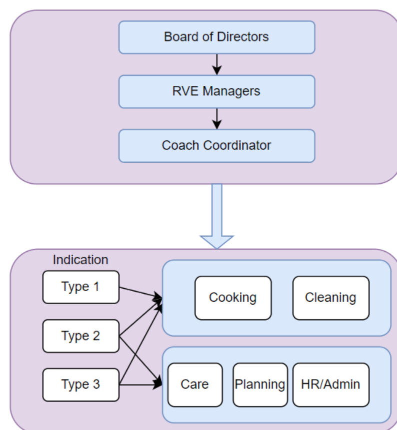

Figure 9: Organisational structure before COVID

4.1.2 Organisational structure changes because of COVID-19

The changes because of COVID-19 points at the structure changes made because of COVID-19. Topics of are scaling down care, measures to prevent spreading, COVID-19 infection residents, COVID-19 infection colleagues and COVID-19 decision structure.

In the location with high COVID-19 infections the planning tried to put the infected and suspected COVID-19 cases into one route or at the end of the route. The care worker and nurses are then visiting the COVID-19 residents in a row which means that they have to get changed every time when visiting a new COVID-19 resident. With the change in the route, they wanted to prevent spreading and make it easier for the care workers and nurses to do their jobs. When changing the route and only visiting patient with COVID-19 or COVID-19 suspects is a form of a lower degree of functional concentration, because they only visit one patient group. This also means that the support disciplines are not visiting the resident. When the infections raised, this way of working was stopped.

> *"Then there were, for example, four or five and then one person there went to the COVID patients and then I took something from that route, for example. Do you know that you can of course not do it all? In itself it went when there were even fewer people, it went well then."* (Respondent 4, Women, Care worker, Location with high COVID-19 infections).

During the COVID-19 pandemic there was a special task force who made the COVID-19 policies, CCT. The CCT consists of only RVE managers who decide what the policies are. They communicate the policies to the coach coordinator of every location. Every week there is the opportunity for every coach coordinator to ask questions about the policy. And the coach coordinator informs the care workers and nurses about the new policies. This indicates a change in the degree of separation between production and control structure. Because of the new CCT, there is an extra control layer, which causes a higher degree of separation.

> *"Well, I know that at least it still is so now, so I assume it was then. The organization has a CCT that is a corona coordination team. And there are MT members who discuss, say, the trend in the country, but also the relaxation that is agreed nationally and they discuss this within that team, the CCT. This is where decisions are made about policy within the organization. And as C&C we always receive the minutes and then there is also a question hour for the C&C every Wednesday at 09.00. In other words, in which announcements are made, but also questions can be asked about policy. In principle, we can of course also communicate this within location and also take questions back to that question time and in addition, there is a current corona policy at a mine, all policy documents and rules are included."* (Respondent 14, Men, Manager, Location with low COVID-19 infections).

These positive tested colleagues caused extra tasks. During the COVID-19 period the care workers and nurses were facing more tasks because of less employees and extra tasks from the infected COVID-19 residents. The extra tasks caused the time for the residents to be limited. Whereas normally they shower the resident 3 times a week, they now only do it once a week.

> *"That is very simple your other activities that you actually come for, which are therefore narrowed. That means that you will become a bit easier in this, that you will start to scale down. Euhm .. when someone really likes to shower 3x a week, it is simply reset to once a week"* (Respondent 1, Women, Nurse, Location with high COVID-19 locations)

These extra tasks caused the care workers and nurses to be forced to scale down the care for the residents. Based on the indication given and care needed the care workers and nurses are looking which care can be scaled down. Sometimes it is just not possible to scale down the shower moments because of the clinical picture. Scaling down the care has an impact on the task structure of the care workers and nurses.

> *"Of course, we have people here from A to Z. With its own past, with its own capacity and also various syndromes. Some people sweat a lot, some people, for example, have someone with Parkinson's and they just sweat every day. And it is not nice that you are helped once a week with washing, washing was still done. But with a shower when you wake up wet every morning in your bed from that urge to move and sweating from the clinical picture that comes with, you do like to be showered."* (Respondent 3, Men, Nurse, Location with high COVID-19 infections)

During COVID-19 some organisational structural changes are made. A structure design has been made to visualize it (see figure 10). The changes in the structure were the same for both cases, which is why the visualization applies to both cases. In the upper part of the organization there has been added a layer to decide how the COVID-19 policies are implementer. The CCT is an extra layer and makes it more difficult for the employees to make their own decisions. By adding the extra layer, the degree of separation became higher. another change is the additional tasks of the support activities (cleaning and cooking). These tasks are added to the care team, but there is not the right amount of personnel to run their support activities, which makes it difficult to perform. By adding the support activities, the differentiation of operational activities has a lower degree than before COVID-19, because they now also perform the support tasks which they normally do not.

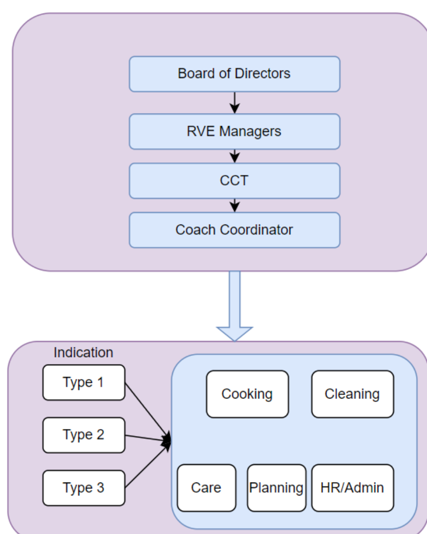

Figure 10: Organisational structure during COVID-19

4.2 Quality of working life changes because of structure changes

In this paragraph the effects of the changed organizational structure, because of COVID-19, on the quality of working life will be discussed. Two concepts are distinguished namely the job demands and job control. In paragraph 4.4 the social support will be discussed.

4.2.1 Job demands

The job demands have a connection with the organisational structure changes because of COVID-19. The concept of job demands points out possible components which can cause job pressure.

Delivering this food to the residents was an extra task for the care workers and nurses. Not only providing food for the residents was an extra task. Because the family of the resident was not allowed to visit their relatives, the care workers and nurses also need to take over tasks from the residents' family like bringing the laundry upstairs, which is laundered by the family and bringing the groceries upstairs. Looking at the two cases, both of them were facing these extra tasks.

> *"In the first lockdown anyway, that was even though that family was not allowed in. Then we had to do the shopping, we had to do everything. We all had to take over what normally the family does. Because they weren't allowed into the building. Sometimes the groceries were dropped off in the hall and we had to bring it to the residents, for example. Or we had to bring something out of the residents to the family members."* (Respondent 13, Women, Care worker, Location with low COVID-19 infections).

Besides the extra tasks of the family, the care workers and nurses, of both the locations, also need to pick up the tasks from colleagues who are tested positive on COVID-19. *"With the same / less people, because in our team it was of course still euhm .. a lot of dropouts. Yes, so that euhm .. the workload increased enormously."* (Respondent 1, Women, Nurse, Location with high COVID-19 infections). According to the employee satisfaction survey the most common reason for a higher workload is because of the schedule, about the moments that employees are able to turn up at their work and that they can do the shift that they are scheduled for. Another reason why the care workers and nurses have extra tasks is the frequency in which they visit residents. Some residents who were infected need sometimes 8 to 9 care moments a day, where normally they only visit the resident twice a day.

> *"And what in the end, what becomes of a plus one is two, what you then get is care demand becomes more, staff is too short, your mental and your energy also decreases."* (Respondent 3, Men, Nurse, Location with high COVID-19 infections).

These extra tasks should be done within the same time. And these tasks are time consuming, which puts the care workers and nurses under time pressure. In both the cases care workers and nurses were

feeling this time pressure. Respondent 12 (Women, Care worker, Location with low COVID-19 infections) stated that the time pressure was the most challenging part of the COVID-19 year *"the time I think, the time you don't have but have to spend.*". For the care workers and nurses, these extra tasks came next to the normal tasks which made the time pressure even a bigger problem. For example, bringing the food upstairs and putting it in the refrigerator.

> *"Yes, it's just less time for the residents. That just became yes ... in principle if you would do something extra with the resident, yes you did not at that time. You then outsource that for groceries, for example. Then you had family members who, for example, had put down messages. Then it had to be put in the fridge and then it all took just a little too long according to the family of the resident and they just got angry there too. So yes there was all time pressure behind it."* (Respondent 13, Women, Care Worker, Location with low COVID-19 infections)

The care workers and nurses are having limited time because of the increasing time pressure. The extra tasks and higher pressure cause them to be faster and leave the resident earlier. For the care workers and nurses, in both the locations, this is hard because they feel that they cannot deliver the care that the residents deserve. Leaving the residents earlier also means that they need to scale down care sometimes.

> *"Yes that is very frustrating, that is absolutely very frustrating. Where you normally ensure that you have a conversation with the client while washing the dishes and getting dressed, you can now only do one thing. I have to leave the house as soon as possible because there is still a lot waiting. So, um and that's not what you want because healthcare workers want to take care of them, and they don't want to rush around, and I really had the idea that we have failed that client uhm .. in many areas. Because we just couldn't do anything else."* (Respondent 1, Women, Nurse, Location with high COVID-19 infections)

For the care workers and nurses taking care of the residents is very important. They stated that is why they are working in care, to take care of people who need it the most. It is not about the extra tasks, but they do it for the residents. *"I didn't mind the extra task, because you do it for the people"*(Respondent 11, Women, Care worker, Location with low COVID-19 infections). The most important part for them is to be able to give the care they need. According to the employee satisfaction survey the second most common chosen factor for high workload during COVID-19, is that the employee has limited time for the resident. But it is not only the quality of care, but they also want to spend time with the residents and see that as an important part of their job. It is hard for the care workers and nurses to not be able to do this. This problem is also something that the employees in the other location are facing.

"I was very sorry to see that. We also do not have the time to sit with the residents because you get extra tasks. Normally you say well then you drink a cup of tea there. You just don't have that time." (Respondent 12, Women, Care worker, Location with low COVID-19 infections).

4.2.2 Job control

The concept of job control is about the ability of the employees to deal with the problems which occur during their work. But also, the possibility to make their own decisions during the COVID-19 period, when there is no policy for that or when they face problems.

During the COVID-19 period the CCT made the decisions about the COVID-19 rules and policies. They communicated it to the coach coordinator of every location, and they made it clear to the care workers and nurses. Making the changes in these policies were not possible for the care workers and nurses. They should go to the coach coordinator who decides what happens and they have made it clear to the CCT.

"The organization has a CCT that is a corona coordination team. And there are MT members who discuss, say, the trend in the country, but also the relaxation that is agreed nationally and they discuss this within that team, the CCT. That is where decisions are made about policy within the organization. And as C&C we always get the minutes forwarded and then there is also a question hour for the C&C every Wednesday at 09.00. In other words, in which announcements are made, but also questions can be asked about policy." (Respondent 14, Men, Manager, Location with low COVID-19 infections).

To sum up, the ability to make decisions when possible problems occur is important. Sometimes the care teams of both locations are not heard and that gives frustration and can lead to possible stress. For the care team it is important to be heard and that the organisation is doing something with the feedback that the care team provides. With the additional control layer (higher degree of separation), there is even less space for the care workers and nurses to make own decisions regarding strategic and policies matters.

4.3 Changes because of COVID-19

In this paragraph the changes because of COVID-19, who do not concern the organisational structure, are discussed. These changes are for example wearing the measure materials and the procedures when an infection appeared in the location. These policies discussed below applies to both the cases in this study, because these policies are organisation widely deployed.

When a resident is tested because of possible COVID-19, or they are tested positive the organisation initiates a process. First the resident goes into quarantine. This means that the resident is not leaving his or her apartment anymore. The care worker and nurses are giving care in complete protection. They have to put on safety glasses, aprons, gloves and face masks. All these protection materials are stored in the hallway of the residents' apartment. The hallway is transformed into a sluice. The resident is not permitted to enter the sluice. *"Until that is proven negative. Then you could let it go. But immediately a sign was put in the hall and there was a sluice. The residents were therefore no longer allowed to come there."*(Respondent 5, Women, Care worker, Location with high COVID-19 infections).

In this sluice the care workers and nurses get changed and prepare for entering the apartment. After they visited the resident they disinfected their hands and the glasses. All the other prevention materials are thrown away. Before leaving the resident they need to get changed again and refill the prevention materials in the sluice. This process takes up to 10 minutes.

> *"Yes, that was all a bit delayed for you because yes look if you have a morning route then you say so many people in it. If you then unexpectedly have to put on a suit, look you can add time to that resident. Well, I have been there instead of 10 minutes, I have been there for 20 minutes. But that does indeed mean that if I have to be with someone at 09.00, I will be there at 09.15 and everyone moves up and then you are actually working longer."*

While working in the COVID-19 period, some colleagues were tested positive of COVID-19. This meant that they cannot come to work, and the shift or tasks should be transferred. When an employee tested positive, they should stay home until they felt better.

> *"Yes there was certainly less staff and sometimes, how hot they were at work, because we had to work even though you were tested. Then I came in at once. Yes, I have to go home. I am positive, okay. Well, he will drop everything and then someone else has to pick up something again, which is okay because we all do it together, that is all fine."* (Respondent 12, Women, Care worker, Location with low COVID-19 infections).

At a certain point the COVID-19 cases within the team of the location with high COVID-19 infections were growing rapidly. Most of the employees were infected and the tasks should be divided between the care workers and nurses who are able to come to work.

> *"And that's where it started to roll and in the end just about 80% of our team unfortunately had the virus. And that means at those moments that the workload of*

> *other colleagues has increased enormously.."* (Respondent 1, Women, Nurse, Location with high COVID-19 infections).

Looking at the measures to prevent spreading in the location, in one location they separated the two wings of the location. Part A and Part B were separated from each other to prevent spreading from one side of the location to the other side. *"And what also happened in the meantime is we had made a distinction in the lockdown between team A and B of the people who don't visit each other."* (Respondent 3, Men, Nurse, Location with high COVID-19 infections). This separation also meant that the care worker and nurses of both wings couldn't meet each other on the work floor. So also, the teams were separated. Important measures to prevent the spreading of the virus were the facemasks, gloves and hand alcohol. Care workers and nurses needed to disinfect their hands and wear face masks all the time during their working day. Only when they had a break could they put off the face masks. The care workers and nurses were trying to put everything in place to protect the residents. Because of the lockdown in the locations, the grand cafe was closed, which means that the residents needed his food in the apartment.

> "*As usual, people go downstairs to eat hot food in the afternoon, but at a certain point it was no longer allowed, the grand cafe closed. Everyone has to get the food upstairs, how are you going to do that? From one day to the next it was decided it would close. And you save with it. Yes then you have stress you know. Then you have to bring all the food upstairs in half an hour and spread it over four floors with six people. That is, um, hard."* (Respondent 12, Women, Care worker, Location with low COVID-19 infections).

To make it clear that the resident is in quarantine, a sign is put on the door so other residents are aware of the fact that they cannot visit the resident in quarantine. For the dementia patient it is tougher to understand the quarantine process.

> *"There is then a sign with quarantine and the neighbors also know that they must not go inside. Or sometimes it is very difficult because some people just leave their apartment. Yes, they are the dementia, and they have no idea what they are doing and were happy that the people who are not called what turned out to be negative later on. But the people who were positive, yes they really stayed in their apartment."* (Respondent 9, Women, Care worker, Location with low COVID-19 infections).

In order to make them aware of the fact that they need to stay in the apartment, the care worker and nurses place signs within the apartment to make sure the resident with dementia stays inside of his or her apartment. To make it more workable for the care workers and the nurses, the dementia residents were moved to another department.

"People uhm .. let's say the residents there tried to understand, but we had so many demented people at that time. They have been transferred to some sort of department. That gave us a bit more peace of mind, so yes again to continue the work a bit." (Respondent 2, Women, Care worker, Location with high COVID-19 infections).

4.4 Quality of working life because of COVID-19

In this paragraph the consequences of the changes because of COVID-19, on the quality of working life, are discussed. Three concepts will be discussed namely, job demands, job control and social support.

4.4.1 Job demands

During the COVID-19 period the care workers and nurses were facing emotional exhaustion. The depletion of residents is something that was hard to see for the care workers and nurses. The depletion is not only because of COVID-19 infection, but also because of the indirect effect of COVID-19 which gave them mental and physical problems.

"And then yes that actually affects me the most and I see just because I am of course on the work floor that the number of my people have also just so err yes actually physically and mentally deteriorated so much because they don't have that bit of social life." (Respondent 10, Women, Care worker, Location with low COVID-19 infections).

It was tough for the whole team, of both locations, to see the depletion of the residents. This had an effect on all the care workers and nurses. *"That has done quite a lot to us mentally. Because you saw people just slide down, people especially with cognition problems you will slide down um .."* (Respondent 1, Women, Nurse, Location with high COVID-19 infections). It is not only the depletion of residents that has an emotional impact on the care workers and nurses, but also to see the residents lonely. Social isolation is seen as a reason for depletion, especially for the ones with cognitive problems. But also, to see the residents lonely, because they are not allowed to go to family or go to a game night in the location, was hard for the care workers and nurses.

"*That's awful, that's really sad. We had a lady here and that yes just completely cankered inside and at one point she was not allowed to see anyone at all, she was not allowed to go outside and to go anywhere."* (Respondent 11, Women, Care worker, Location with low COVID-19 infections). It gave them a powerless feeling to see the resident all alone in their apartment.

The care workers and nurses are near to the fire when it comes to COVID-19 infections. They are facing more risks to be infected, infect family or infect residents. The fear of infecting someone is different among the care workers and nurses. Most of the employees of both locations are not afraid to infect residents because they take all the prevention measures necessary.

> *"Yes, yes, yes like I said yes just I was always extra careful anyway. And so, try to keep it 1.5m, but that was not feasible in very cases anyway. And furthermore, wash your hands regularly with alcohol. So, I did what I had to do. But I did not go all day in my head like oh my I might infect that or that so no not that."* (Respondent 13, Women, Care worker, Location with low COVID-19 infections).

But infecting their relatives was something that some employees were afraid of. When working in an environment where COVID-19 is, gives a higher possibility of infection to someone outside of work. One employee infected her husband twice, this was something that was hard to deal with. The employee stated that she was fine to get infected for himself, but it was tough that her husband got infected.

> *"Yes euhm .. well to my house not so euhm .. yes for my husband look if he would get very sick but I was very sick the first time and the second time a little less and it was just different for him. Then you have a certain fear of shit, it will come through me and um .."* (Respondent 2, Women, Care worker, Location with high COVID-19 infections).

When looking at the possibility of getting infected themselves, most of the care workers and nurses of both the locations were not afraid of getting infected themselves. They state that they know the rules and when sticking to those rules they do everything that is necessary to prevent the infection. So, they do not feel the fear of getting infected.

> *"No actually not. No, I'm like you know the rules on how to protect yourself at work and what to wear. Do you know that afterwards you have to throw it away, wash your hands well and disinfect it?"* (Respondent 12, Women, Care worker, Location with low COVID-19 infections).

Due to the COVID-19 changes the care workers and nurses need to protect themselves to prevent spreading towards the residents and themselves. They are obligated to wear these prevention materials, like a facemask, all the time at work. Only during the break can they put off the facemask. *"And in terms of rules yes you have to walk continuously with a mouth mask"* (Respondent 11, Women, Care worker, Location with low COVID-19 infections). When they are in the office, they are also allowed to take off their facemasks. Sometimes they step by the office to get some fresh air.

> *"What you try then yes no .. it is not pleasant. I still have that now that I think of pff quickly to the nurse's office and then take off the mask. Yes."* (Respondent 2, Women, Care worker, Location with high COVID-19 infections).

For the care workers and nurses of both the locations, it was hard to work with the measures. While giving care and walking through the hallways there were obligated to wear masks. They were not able to get some fresh air or to get a drink during work time. This caused some of the employees physical problems while working, like headache and thirst.

> *"And um .. you know normally you can just bring a bottle of water and per client I put it away and I can drink. And I just couldn't drink anymore. You walked around with a headache, you walked around thirsty, you had to keep that mask on until your next break. And at one point we felt like boys, but we also had to stay healthy, we had a lot of headaches"* (Respondent 1, Women, Nurse, Location with high COVID-19 infections).

When a resident is suspected of COVID-19 or they tested positive on COVID-19, the care workers and nurses of both locations provide care in a suit. They were not looking forward to wearing the suit, because they didn't like giving care in the suits. *"I was not looking forward to wearing it, not to go in, absolutely not. But to wear the suit, yes. I hated that."* (Respondent 9, Women, Care worker, Location with low COVID-19 infections). Besides that, they were not looking forward to wearing the suits, it was also difficult and time consuming to put on the suit. *"Warm .. It was a hassle to put it on and take it off"* (Respondent 12, Women, Care worker, Location with low COVID-19 infections). Providing care in the residents' apartment was hard for them. Sometimes they were stuffy when wearing the suit. *"They were also like gosh there they come again all in a suit. And I found it terribly stuffy to work."* (Respondent 10, Women, Care worker, Location with low COVID-19 infections) The residents are ageing and most of them turn on the heating. For the care workers and nurses, it was very warm to wear the suits. In both the locations the care workers and nurses were facing problems with the warmth.

> *"Yes in itself it is doable, but uhm .. then of course you also knew that then you go inside someone, and you do your thing there and you are there for half an hour or an hour and then you can take the suit off again . Then you can also ventilate in the hallway, but it is just warm."* (Respondent 4, Women, Care worker, Location with high COVID-19 locations).

Sometimes it even led to sweating of the care workers and nurses.

"I find it very difficult. I really don't like it and I sweat it lubber. And because it is so hot inside with those people because how hot I like to go outside. And like in winter it is -15 outside, but with those people it is +30 inside, then you have a difference of 45 and then you also have to wear such a suit, which is really not pleasant." (Respondent 9, Women, Care worker, Location with low COVID-19 infections).

While providing the care they also face problems. When showering the resident, they need to be close and also wear protection. Not only when the resident is suspected or tested positive, but also when there is no COVID-19 threat they need to wear a face mask when they put the resident in the shower. When showering the resident this leads to a stuffy situation for the care workers and nurses of both the locations.

"Euhm .. well with the shower moment you have that it gets very stuffy in one go. Because the residents also want to have the doors closed and you still have your clothes on, your work coat and your mouth mask. It was actually yes .. stuffy." (Respondent 13, Women, Care worker, Location with low COVID-19 infections).

Most of the care workers and nurses agreed that wearing the face masks was important to prevent the spreading and were doing it for the residents. But not everyone agreed with this. An employee stated that it was nonsense to wear a facemask. It was a bit too much and suddenly measures were required.

"I struggled with it for a few days before the switch. I thought it was all a bit of nonsense anyway. For me it was all a bit too exaggerated, just a bit too much. All sorts of things have to be done at once, I think yes yes .." (Respondent 13, Women, Care worker, Location with low COVID-19 infections).

In the COVID-19 pandemic the residents' family was not welcome in both of the locations. After that period the family was welcome, but they should stick to the rules. These rules were set up by the organisation to make sure that the virus is not spreading in the location. But the residents' family does not follow the rules all the time. The care workers and nurses of both the locations need to address the family members to the rules. For the care workers and nurses this was annoying

"Not what's that, I found that really annoying. Sometimes we came in and then there were just four people inside. Then we said boys this is really not the intention and then we got a big mouth from them again. Yes and at some point you see that, and you turn around and say okay boy I'm going to run away again. And then it's like yes they still have to and then I say you are still there, do your best. I will give the medicines when you are gone, but you are here to make sure she gets food and

> *drink, but I am leaving."* (Respondent 9, Women, Care worker, Location with low COVID-19 infections).

Every time the resident or the family of the resident does not follow the rules, the care workers and nurses need to correct them and emphasize the rules. While the care workers and nurses are doing the best, they can prevent the spreading, the residents and their family don't take it that seriously. For the employees of both the locations it is hard to see this. It was even demotivating for them.

> *"Yes, it was frustrating and demotivating. Yes because yes at some point it will bring you to the point that you think well late but I'm not going to talk about it now because it makes no sense anyway."* (Respondent 11, Women, Care worker, Location with low COVID-19 infections).

First the employees were feeling like cops, because they were continuously repeating rules. *"Then you really feel like a police officer."* (Respondent 1, Women, Nurse, Location with high COVID-19 infections). It even went that far that the organisation needed to call in security in both the locations to address the residents and their family to the rules. For the care workers and nurses of both the locations, it was strange to have security around. Mostly because they do not understand why the family does not stick to the rules.

> *"I thought it is crazy that this is necessary. Of course, you know, of course I understand that you miss your father or mother. We all understand that. But think of it at some point you have to think of euhm yes and if you infect that person and then we? We mean we still walk there too. And look when we do, if they fall over even more then we can indeed no longer help your mother because then it is simply impossible to knit and that, I found that difficult."* (Respondent 4, Women, Care worker, Location with high COVID-19 infections).

The COVID-19 pandemic is new for everyone, which causes some uncertainty. The government is making policies to prevent the virus from spreading. But also, the organisation makes policies to prevent the spreading. But no one is familiar with this kind of situation. This also has an impact on the care workers and nurses. They do not know what they can expect. Every day is a day with surprises and possible setbacks.

> *"Especially hectic in the beginning. Because you don't know what it is, what can you expect, where are we going, how long will it take. So, the beginning was a big mess. You hear on TV this is no longer allowed, that is no longer allowed, and the family knows nothing about it. Everyone has questions that you can't really answer*

> *because you don't know anything yourself. Yes, the work suffers."* (Respondent 12, Women, Care worker, Location with low COVID-19 infections).

Besides this it is also hard for the care workers and nurses of both the locations, because there is no guideline for what they need to do. They are trying to do the best for the residents, but they do not know what that is and how they can accomplish that. So, the uncertainty is something that has an impact on the care workers and nurses. During this time, they tried to find a way to work together.

> *"And our feeling indicated at the beginning that we don't actually walk around like a chicken without a head, but it would have been nice if we had the information we now have. That we actually had it available at the time."* (Respondent 2, Women, Care worker, Location with high COVID-19 infections).

During the COVID-19 period it was hard for the care workers to keep their work and their private situation separated. According to the results of the employee satisfaction survey, the work/private balance was the second most common reason for a poor working environment. They were in continuous contact via WhatsApp, especially in the locations with the higher COVID-19 infections. They got messages when some was tested for COVID-19 or when someone tested positive. Then they knew that shifts and tasks needed to be transferred.

> *"Your head is just working overtime at those times. And at home the app was often also thrown into the app, guys, there is a new case, yet another infection, what about this and how are we going to do it. In fact, you are constantly working in your head 24 hours a day with care. So being able to let go was very difficult!"* (Respondent 3, Men, Nurse, Location with high COVID-19 infections).

To sum up, during the COVID-19 period the care workers and nurses are exposed to extra tasks, and this causes them time pressure. These factors caused the employees to feel poignant, powerless and terrible. The resident is important for them, and they have a hard time seeing them deplete or lonely because of the isolation which is caused by the COVID-19 pandemic. Besides the resident also the danger of infecting someone is something that has an impact on the care workers and nurses. They are afraid of infecting someone, especially people at home. The experience of the COVID-19 pandemic was a bit more extreme at the location with the higher COVID-19 infections. For them it was a bit tougher then for the colleagues in the lower COVID-19 infections location.

4.4.2 Job control

As mentioned earlier the loneliness of the residents had an impact on the care workers and nurses. They had a tough time seeing the resident in social isolation. Social isolation was a policy made by the government. It was bringing mixed feelings to the care workers and nurses. They were doubting

sometimes if social isolation is the best for the resident. They saw the loneliness and the depletion of the residents. The fact that the care workers and nurses, of both the locations, were not able to do something about the loneliness was frustrating.

> *"Yes we weren't even allowed to. I found that really frustrating. Because you really saw the people, some people just deplete because yes they wanted to do something with people, with their own group. What is that called at one point, yes there was a bingo night but that was for example for certain people. That was half a year later and I think you could have done something, arranged something in that half year. You see so much at those other Livio locations, you see a lot of fun things being done in the corona time and then with us nothing was allowed at all. And then we said something about it and then they said no it is not going to happen because that is all possible because yes the people who can just get corona and everyone had to protect themselves. Yes .. sigh .."* (Respondent 9, Women, Care worker, Location with low COVID-19 infections).

Respondent 9 (Women, Care worker, Location with low COVID-19 infections) also added *"We had absolutely no control about that"*. No control over such a situation has a negative effect. Besides the fact that they have no grip on the loneliness of the resident, there is also the fact that the work must go on. They have no choice but to let go of the tasks, because the care continues. *"No, because most things were imposed so yes you have to adhere to that. So yes .. you don't really have a choice."* (Respondent 12, Women, Care worker, Location with low COVID-19 infections). *"You know you just do it, just an automatic pilot because it was just mandatory so yes you did it on the side."* (Respondent 13, Women, Care worker, Location with low COVID-19 infections).

When a colleague was tested positive, there were tasks who came free and needed to be taken care of. The authority for the coordination was with the care workers and nurses from the care teams from both the locations. They could divide the tasks between themselves. *"Yes, actually we have all done it ourselves. And then you run into things that don't work and then you look at which disciplines there are more and what can we fall back on and um."* (Respondent 1, Women, Nurse, Location with high COVID-19 infections). When the work was overflowing the care teams could call the coach coordinator of their location to look for possible solutions. When they addressed it and there were possibilities to call in extra help, it was done. *"As soon as we sounded sorry we just couldn't make it, we needed someone with a care background then he was there too "* (Respondent 2, Women, Care worker, Location with high COVID-19 infections). When the video calling made its appearance, not everything was running smoothly. To take care of this the care team was able to change the video calling structure so it was better workable. *"For some it was beautiful to see how emotional they are and for others it only caused unrest. So, at some point we expanded it to other people and stopped it*

with other people because that just couldn't be done"(Respondent 2, Women, Care worker, Location with high COVID-19 infections). It was not always that the care worker and nurses had the feeling that they could change possible problems. Sometimes they say that they have the feeling that they are heard, but nothing changes.

> *"Yes what's that I don't know. I cannot, I cannot explain it because yes, I enjoy working. Yes, I like it, I really enjoy working there, there are a lot of things around it that I think goddamn why, why are we not being heard. We report a lot of things, and nothing is done with them, I think, but the other colleagues find that very difficult. That is something you will run into. We run into that very much, but that is already before corona. This has been going on with us for years. We have like this, we are actually not allowed, but we are so used to that that at some point we feel like we say something about it and at some point we feel like we are talking to a wall anyway."* (Respondent 9, Women, Care worker, Location with low COVID-19 infections).

To sum up, job control is very important for the nurses and care workers. Regarding their own operational activities, they have control to handle with certain disturbances, but when it concerns strategic or policy changes, they do not have the authority to make the changes. So, there is a high degree of separation between the production structure (control over operational activities) and the control structure (control over strategic and policy activities). This makes it difficult for the nurses and care workers to handle some types of disturbances which are policy or strategic related.

4.4.3 Social support

The last concept is about social support. The support points out who and what gives strength to the care workers and nurses to do their jobs and handle the negative aspects. But there is also a counter argumentation that support can have bad consequences either. The concept of support consists of five components: family support, peers support, patient/family support and negative contact with residents' family. These five concepts were visible in both the higher and lower COVID-19 infection locations.

As mentioned before in the job pressure part, the violation of rules had a negative impact on the care workers and nurses. Attending people on the rules and asking them to follow the rules had some bad consequences. The family of the resident had a negative impact, in terms of the contact with the care workers and nurses, on the care workers and nurses.

> *"Besides the fact that it just has a very negative influence and that it demotivates you to work, it is just energy guzzling and time consuming. We could have used the time that yes had actually spent with people like that and that we just had to spend*

> *with all respect to be able to prevent escalation from happening to take care of the people who needed it at that moment."* (Respondent 3, Men, Nurse, Location with high COVID-19 infections).

It reached a point that the care workers and nurses preferred that the family was not around anymore. The absence of the family gave them a more peaceful feeling and the opportunity to do their job. *"Then the misery started again you know. The turmoil again. And it is also logical that people would like to visit the family. But you were like please stay away, then there is peace in the tent."* (Respondent 2, Women, Care worker, Location with high COVID-19 infections). The negative contact with the residents' family even reached the boiling point with one care worker. The family threatened her, and this had a large impact on her and the team.

> *"That was very intense. That was really intense. Yes because I was home for 14 days before that I just couldn't work anymore. I was really taken aback by that, now the tears are almost in my eyes again. Because I was put by name and shame and with a photo I was put on Facebook and there were all kinds of nonsense things about me and yes .. that grabbed, that even grabbed everyone who works with me."* (Respondent 9, Women, Care worker, Location with low COVID-19 infections).

For the care workers and nurses there was not only negative contact with the residents' family. In contrast, most of the family members showed respect and appreciation. This was something that was appreciated by the care workers. The family showing respect and appreciation for what they were doing, gave them strength to do their jobs.

> *"I say they are sometimes very simple things but when you start video calling and the family is radiant on the other side and become very happy that you took your time for that, yes that gives real strength. Then you really hang up with a feeling that you think it's great that I could do this for the family. That the family could have a chat with father or mother. So yes um .. that certainly gave strength!"* (Respondent 1, Women, Nurse, Location with high COVID-19 infections).

It was not only about the strength, but they also felt supported by the families which was something that helped them through the COVID-19 period.

> *"That's great! I felt really supported by that and that also means that you can increase the willingness of family, so that also means that if you ask them something now, I think that it builds up quite a few credits in that . The contacts have really become stronger in this regard. In most of the families."* (Respondent 11, Women, Care worker, Location with low COVID-19 infections).

Looking at the negative contact, some say that it was good to find a balance between those two. *"And on the other hand, we got cake from people from the top what you do, keep it up! We were able to find the balance, but it is an aspect that made our work more difficult at that time"* (Respondent 3, Men, Nurse, Location with high COVID-19 infections).

Besides the family of the resident, the own family also plays a role in the support for the care workers and nurses. They had the feeling that their family helped them. *"And my family has helped a lot"* (Respondent 2, Women, Care worker, Location with high COVID-19 infections). Besides the help, they also felt supported by their families. *"That is difficult, hey yes groceries and err .. packages are bought and put on the driveway. Neighbors who called every day if they could do something for us, yes really very sweet all. Everyone wants to help you."* (Respondent 2, Women, Care worker, Location with high COVID-19 infections). But the most important support for the care workers were their own colleagues. Through the day and the whole COVID-19 year they had support from each other. Some say that their bond has grown over the last year. *"I think you grew closer"* (Respondent 12, Women, Care worker, Location with low COVID-19 infections). The support not only comes from saying nice things to each other, but also taking over work from each other and even staying late to help colleagues.

> *"During the corona we also had something like we will get it finished. We started making a lot of extra hours just to be there. Because otherwise your colleague has to do it alone. And you try to get it done. They say the care is 24 hours. At one point you also went into the night with the two of you, which also costs more staff. Yes so yes you really keep busy .."* (Respondent 2, Women, Care worker, Location with high COVID-19 infections).

For them it was seen as a strong team and that gave strength to them. *"Yes, I think that was the main reason why we as a team have been through this."* (Respondent 3, Men, Nurse, Location with high COVID-19 infections). This was also the most important factor of the employee satisfaction survey. The survey showed that colleagues were the most important factor for a positive work environment during the COVID-19 period. Important were: *"Colleagues and Team: great cooperation, great, good, nice colleagues"* (Employee Satisfaction survey).

During the COVID-19 period communication was important. Multiple times there was no clear communication from the organisation. This was also one of the main things that had a negative effect on the work environment according to the employee satisfaction survey. They stated that: *"Communication (much unclear, past each other)"* (Employee Satisfaction Survey). For example, the communication from the organisation to the residents and the family of the residents, but also the communication between within the organisation. When the communication is not clear, the residents,

their family and the employees do not know which rules to follow and what the guidelines are. *"Yes, the guideline was there, but it was more purely aimed at the family, and it changed so often that at one point the family members and the residents no longer knew what is and what is not allowed."* (Respondent 13, Women, Care worker, Location with low COVID-19 infections). The respondent also points out that the guidelines are changing very fast. These continuous changing rules make it tough to stick to the rules, when it is not communicated properly.

> *"And it just wasn't clear we had no frameworks, no policies for that. As an organization we also had to look into this very much and the policy sometimes changed every week and in the beginning of last year when at the beginning yes at the very beginning of the corona period, so what we knew from that second period was already a lot more. something on paper and we were able to act very quickly if something happened."* (Respondent 7, Women, Manager, Location with high COVID-19 infections).

Adding to the communication of the policies is the aspect of unclear policies. To be able to stick to the rules, the policies of the organisation must be clear.

> *"Yes, they did not follow the rules, so with one they made an exception and with the other not. Like one family was not allowed in and the other was still allowed in there. As the family is not allowed in there were construction workers who were allowed in, so it was a bit confusing as to what was and was not allowed. Uhm .. yes .. yes .. otherwise, I actually thought it was yes, good."* (Respondent 13, Women, Care worker, Location with low COVID-19 infections).

Because of these unclear policies the care workers and nurses were not able to give answers to the resident and their families which caused problems.

> *"In the beginning that gives even more stress, because of course the family has a lot of questions. But we also have the same questions, which you cannot answer to yourself, but not to family at all. And that is of course completely frustrating for the family. They want to know where their father or mother ends up. That is completely annoying for them. Yes .."* (Respondent 12, Women, Care worker, Location with low COVID-19 infections).

So, communication is important for the care workers and nurses to be able to understand what the policies are. When communication fails it is hard to stick to the rules and unclear policies make it difficult to answer the questions. When the communication and policies are not properly done, it can cause stress because they are not able to follow the policies and to answer the questions asked. With

the CCT making the policies and communicating them to the operational people it makes it sometimes difficult to understand. Because of the fast changing policies, the policies become unclear. Also, it is important for the care workers and nurses to get support, especially in such hard times. Negative contact can have a negative impact on the employees. For them it is the most important to have support from colleagues, working in a strong team gives them strength. They do not let each other down.

Chapter 5 Discussion & Conclusion

In this section the interpretation of results, conclusion, will be presented. Theoretical and practical ramifications will be examined after that. Following that, the limitations and related directions for future research will be highlighted, followed by a reflection on the researcher's role.

5.1 Interpretation of results

The workload for the care workers and nurses was already high (De Veer et al., 2007; Franzosa et al., 2019), but during the COVID-19 pandemic the workload has even increased more (Grabowski & Mor, 2020; Maslach et al., 2020). COVID-19 made some problems visible and showed the urgency of the workload. Because of the COVID-19 pandemic the task structure of the care workers and nurses changed, and this had a negative impact on the perceived quality of working life. By doing more at the same time and sometimes even with less employees have asked a lot from the employees.

The results were interpreted by the three dimensions of Karasek (1979); job demands, job control and social support. The connection with the organisational structure will be made to see what the effect of the structure is on the perceived quality of working life during COVID-19. To begin with, during the COVID-19 pandemic a lot of things changed in the care sector. These changes had an impact on the structure of the organization, especially the task structure of the employees of both the locations. All these changes were made to get a grip on the coronavirus and to prevent the virus from spreading across the locations. An important change was the lockdown during the first COVID-19 wave. The lockdown meant that the family of the resident was no longer welcome in both the locations. The absence of the family brought a lot of tasks for the care workers and nurses. Tasks like doing the laundry or doing groceries cannot be done by the family anymore. So, the lockdown caused a task structure change for the care workers and nurses. During the lockdown, the absence of the family was not the only reason why the tasks of the care workers and nurses changed. In the beginning of the pandemic the supportive departments like the kitchen and housekeeping were not welcome either. So where normally the residents can join the grand cafe to have dinner, or the kitchen personnel bring food to the residents' home, now the care workers and nurses, of both the locations, had to perform these support tasks. This led to a lower degree of differentiation of operational activities, but still this

had a negative impact on the perceived quality of working life, because there were not enough employees to get these tasks done.

Besides these lockdown measures, there was also the fact that employees needed to work with measures to prevent the spreading. Working with these measures changed the way they had to work. It puts more pressure on the care workers and nurses of both locations because the working conditions were unpleasant. Despite these measures, colleagues got infected. When the employees get infected, their shifts become open and should be taken care of. Sometimes this meant that employees had to work extra days, or the tasks of the shift were divided between the employees who were already scheduled for the day. But the infection of a colleague had an impact on the tasks which should be done. When the already scheduled employees had to take over tasks, they again got extra tasks added to their own tasks. So, there are three causes for extra tasks and thus a change of the tasks structure, which had an impact on the care workers and nurses. These extra tasks put the care workers and nurses under time pressure. Before COVID-19 the care workers and nurses already faced high time pressure, but this has increased because of the extra tasks which have to be done because of COVID-19. High time pressure has a negative impact on the perceived quality of working life (Karasek, 1979). According to Karasek (1979), time pressure is one of the components for job demands. The time pressure also had a negative impact on the time available for the residents. For the care workers and nurses, it is hard to not have enough time to provide the care that the resident needs (Edberg et al., 2008). The lack of time for the resident was also the second most shared reason for high workload, according to the employee satisfaction survey which was handed out within the organisation. So, the changes made in the task structure had a negative impact on the perceived quality of working life of the care workers and nurses.

An important factor for the perceived quality of working life is the job control over the job demands (Karasek, 1979). Normally the care teams of both locations are self organising. They are in control over their own planning and have a say in the recruitment process. The respondents say that they can make decisions on their own. During the COVID-19 pandemic they can coordinate tasks between themselves. But COVID-19 also brought a change in the decision structure. Because of COVID-19 the organisation added a COVID-19 policy team named CCT. The CCT made the decisions and the care workers and nurses needed to follow these rules and had no influence on them. This caused a loss of control and autonomy for the care workers and nurses. Because the CCT was added, the degree of separation was increased, there was an extra layer added between the production and control structure. For them it was sometimes hard to not be able to change some policies. Besides this, the ability to coordinate their own tasks and to be in the lead of the planning and recruitment had a positive impact. So, by adding the CCT, the autonomy of the care workers and nurses was lowered and gave them less job control. A lower job control in combination with higher job demands lead to a negative perceived quality of working life (Karasek, 1979).

The last concept of Karasek (1979) is social support. Social support can have a positive impact on the perceived quality of working life (Karasek, 1979). Social support is not affected by the organisational structure, but it has become perhaps even more important during the COVID-19 pandemic. According to the employee satisfaction survey, the support of colleagues was the most important reason for work joy. So, colleagues are the most important social support factor. Despite the good social support, support can also have a negative impact. For the care workers and nurses of both locations, the negative contact with the family of the resident had a negative impact on their quality of working life. So, social support became maybe even more important during the COVID-19 pandemic, but also had a negative impact on the perceived quality of working life because of the negative contact with the residents' family.

The complexity of the different types of residents who are not clustered together causes difficulties for the care workers and nurses in both locations. Because the care workers and nurses can have different types of residents into one route and even after each other. This type of care has a high degree of functional concentration which makes the structure very complex. This means that they have to switch within the rules every time. Every different indication has different rules, so this makes it very complex for the care workers and nurses. This 'old system', which is removed in The Netherlands, is still used in this organisation. It causes disturbing moments because the care workers do not know what policies to follow.

In the organisation every respondent has its own apartment. This means that the residents are living in a homelike environment, something which the organisation wants to provide to the resident. The homelike environment ensures that care workers and nurses are more connected to the resident. This type of organisational structure thus causes a more emotional connection with the resident. For some care workers and nurses, the depletion and loneliness of residents is even tougher because of the close connection with the resident. This is caused by the homelike environment structure.

At last, the splitting of the location with high and low COVID-19 infections. Looking at the organisational structure changes, these were the same for both the cases. And also, the measures were exactly the same and the extra tasks and time pressure were there in both the locations. But the experience of COVID-19 was a bit different, this can also be concluded by the number of words used in the narrative story. The people in the location with high COVID-19 infections had more experiences and thus had a longer story. In the location with high COVID-19 infections they experienced more time pressure and workload, then in the location with low COVID-19 infections. In the location with high COVID-19 infections everyone had the feeling that they were under pressure. In the location with low COVID-19 infections, this was divided. One employee of the location with low COVID-19 infections saw it as business as usual and others experienced the time pressure. Despite the difference

between the high and low COVID-19 infection locations, in both the locations they experienced higher workload, time pressure and emotional exhaustion, with one exception.

So, the organisational structure changes because of COVID-19 had a negative impact on the perceived quality of working life. Because of extra tasks in the form of support activities (food delivery and cleaning) and the tasks they need to take over from the family, which causes time pressure, and the measures they need to work with the care worker and nurses had a higher workload. And because of the new CCT (higher degree of separation), the autonomy declined which gave the care workers and nurses less control. Also, the organisational structure changes are the same in both locations, so it does not make a difference if there is a high or low infection rate, the measures and changes are exactly the same.

5.2 Theoretical contribution

In this part the contribution to the theory will be discussed. The theory used in this study is about quality of working life. As discussed in the introduction, most research is done in a non-pandemic situation. This study is done in a pandemic situation, and it gives insight into what aspects of the organisational structure influence the quality of working life during the COVID-19 pandemic. In the literature about quality of working life the focus is mostly on job demands, job control and social support (Karasek, 1979).

Looking at the job demands, important factors are stressors (Karasek, 1979). Important factors are the depletion of patients (Broday, Draper & Low, 2003), death of patients (French, Lenton, Walters & Eyles, 2000), emotional exhaustion (Chong & Monroe, 2015), time pressure and not being able to give the care needed (Edberg et al., 2008). This study contributes to the possible stressors during a pandemic. An important factor that causes stress was the uncertainty of the situation. The employees did not know what to do and how they needed to handle the situation. Because there is little known about COVID-19, they have to handle it with the little knowledge that is available. They have lots of questions, which can’t be answered. Another important factor for stress is the measures that need to prevent the spreading. For care workers and nurses in such a situation, working with measures could lead to possible stress. Working with these measures causes time pressure, mental and physical complaints, which causes a lower quality of working life. And the last addition to the job demands is violation of the rules. During a pandemic there could be strict rules that need to be followed. The care workers and nurses are strictly following these rules, but the resident and the family of the resident are not. This causes possible stress and demotivation. To sum up, looking at the theory about quality of working life, this study contributes to that. In times of a pandemic, uncertainty, working with measures and violation of the rules are important stressors which could have a negative impact on the quality of working life.

Another important aspect of quality of working life is social support (Karasek, 1990). Social support has a positive impact on the quality of working life (Orrung Wallin et al., 2015; McGilton et al., 2007; Edberg et al., 2008; Viswesvaran et al., 1999). When there is a lack of social support, it can strengthen emotional exhaustion and depersonalization (Bakker et al., 2004). In the studies they talk about the positive impact of social support. Important persons involved are peers, family, residents, manager, friends, and the residents. The contribution of this study for social support is the contact with the family of the resident. Most important aspect there is that the negative contact with the residents' family backfires the quality of working life. When the family threatens or does not listen to the employees this has a negative impact on the quality of working life. On the other hand, there is also the positive impact of the family which gives them strength and will to work. So, the impact of the residents' family is very important, not only the positive support, but also the negative support of the family. Besides the positive impact another concept for social support has found to be new. Communication is important for the employees. When they are not provided with the right information, they cannot work according to the rules, and they are not able to answer questions from residents and their family. Communication is thus an important support factor. Internal communication should provide the employee with the right information to be able to do their work according to the policies and rules that are set up.

This study also contributes to the service triangle. The service triangle focuses on the dynamics of management, workers, and clients in service work (Subramanian & Suquet, 2018). In the service triangle there is attention for the work and the client and in the study of Vermeerbergen et al. (2020) they include the manager in the service triangle. From the findings in this study, it can be concluded that the family of the resident is also important. They have an impact on the way in which the care workers and nurses feel supported. The negative contact of the family of the resident can have a negative impact, and positive contact can have a positive impact. So, the family of the resident can be seen as a contribution to the service triangle.

5.3 Practical implications

Besides the theoretical contribution, this study also leads to practical implications and recommendations. In the study of Karasek (1979) there is spoken about the importance of social support. It can help lower the possibility of burnouts (Dierendonck et al., 1998). In this study the aspect of communication is seen as part of social support. The communication is a support activity within the organisation to provide the employees with the right information. Especially in times of unknown situations it is important for the employees to have clear communication. The organisation should draw more attention to this and improve the communication about policies. It should be clear, and the employee must have it available. This does not mean that it should be hidden somewhere. No, it should be clear, provided in the right place and not via email on late night evenings. When the

employees go to work, they shouldn't be able to miss it. By improving the internal communication, the employee should be able to answer more questions and they know what to do when certain problems occur. It is important to get in touch with them and discuss how they want to receive such information and how often.

When the employee was in negative contact with the family, this had a negative impact on the employee. This negative social support causes more change in emotional exhaustion (Bakker et al., 2004). For this reason, it is important to protect the care workers and nurses. Try to get in touch with them and find out what is needed to give them a safe and comfortable feeling. According to the data the usage of security can also backfire for the employee. The residents' family can have a more haunted feeling because of it. So, to be able to help the employee the organisation should keep in touch with the care team and listen to what they think is needed to prevent such negative contact. Or to find a way to deal with this negative contact. Right now, they need to handle this alone, and there is no solution for this.

The third practical implication is about the decision making within the organisation. An important part of quality of working life are the job demands (Karasek, 1979). When a care organisation is in a pandemic and the employees are making long days and getting extra tasks continuously this increases the job demands. Most of these extra tasks are from colleagues who are not able to come to work or family members who cannot come to the location. But the organisation also added video calling because they thought it would be nice for the resident and their family. This decision was made by people who are not in direct patient contact and thus not perceive the same working conditions in such a pandemic. For the next pandemic, when extra tasks are added by the organisation, they should do this in consultation with the care workers and nurses. Together they can find a workaround. If it is decided by the manager, it is difficult for them to find a workaround, because they just have to do it. When this happens, the implementation will fail because they do not have a workaround. So, when extra tasks are added, build a short workgroup with care workers and nurses to discuss how this can be implemented, and if it can be implemented. In consultation these things can be better handled, and this is also better for the working conditions of the care workers and nurses.

The fourth practical implication is about the structure concerning the different indications in the location. Right now, the different indications are not clustered together, and this can be seen as a high degree of functional concentration (Achterbergh & Vriens, 2019). This high functional concentration causes complexity for the employees (Achterbergh & Vriens, 2019). They have to switch every time they visit another patient to see which indication they have. To prevent this, cluster all the indications together, put them into one route. In this way the complexity can be eliminated and there will be no more confusion and complexity for the employees during their work.

The last practical implication is about the time pressure. Because of the extra tasks and the fewer colleagues, the time pressure is rising. A consequence of this is that the care workers and nurses are not able to spend enough time with the resident. According to Edberg et al., (2008) when the care workers and nurses are not able to give the residents the care that they need, they feel stress. For the care workers and nurses, it is important to give the right care. With the shortage of people during such a pandemic it is tough to get enough attention for the resident. At a certain point, some workers from the catering industry were helping them out, by going to the resident and having a chat with them. An idea could be to build a network with people who are open to help when such a pandemic repeat. In this way you could keep the lines short, and you can react fast. By adding those support workers, the care workers and nurses do not have the feeling that the residents are lonely and got too little attention. In this network you could also include employees who are retired or moved from direct patient care to not direct patient care. With them in the network you could even let them take over simple nursing tasks.

Besides this maybe there could come a planning system in which they are able to look if care workers or nurses from other locations are able to jump in. Right now, the care workers and nurses are in charge of their own planning. Via such a system they can plan other people from outside their location to help in their location when there is a shortage of people. In this way the care team is still in charge of the personnel planning.

5.4 Limitations, future research and reflection

The study's limitations will be explained in this paragraph. Aside from that, there will be a discussion on the researcher's role in this study. The first limitation of this study is about the sampling of the employees. The sampling went via the manager from both locations. The characteristics of direct patient contact were provided, but the manager approached the employees. This gave the manager the power to select the employees which they would like to be questioned. When the respondents were suggested, there was no possibility to revise the respondents. This means that there was no possibility to select respondents based on a certain characteristic. So, the manager of both locations affected the sampling and thus might have influenced the results of the study. This could affect the research when the manager selected the respondents with a purpose. The direction for future research is choosing your own respondents. In this study the respondents are chosen by the manager, but in future research the sample can be better spread out. This means that the researcher can choose respondents based on characteristics and look if they differ between each other. In this way the researcher can give a more accurate answer and a more in-depth answer.

The second limitation is about the respondents who participated. In the first sample, locations with high COVID-19 infections, nurses and care workers were included. In the second sample, a location

with low COVID-19 infections, there were only care workers selected. Between the care workers and nurses there is a difference in education attainment and also in activities that they perform within the organisation. This makes it possible that the nurses have a different point of view on some cases. Therefore, the location with low COVID-19 infections can have different outcomes who are difficult to compare to the location with high COVID-19 infections. When looking at the limitations of this study, possibilities for future research can be found. There is the possibility to do a study where the sample is better divided. This means that both samples have nurses included. By adding these nurses, the outcome is better comparable. This would be in favor of the transferability and applicability of the study.

Third limitation is about the fact that the studies are done for the whole population and can differ between individuals. In the theoretical framework (Chapter 2), the Job Strain Control model of Karasek (1979) is discussed. In the theories about quality of working life, they refer to the most people. So high demands are important to be challenged but there should be control over these demands. Not every person likes high job demands, and not every person matters if they work 24/7. So, the results of the study and the theory used are not applicable on all people. It is about the majority.

Fourth limitation concerns the fact that no observations are done. Because of the COVID-19 pandemic it was not possible to do observations in the locations to see what is happening there and how it works within the organisation. Finally, the last direction is about the methods. In future research, with another pandemic, the researcher could do observations, diary, or a short question round at the end of the day. In this way you have multiple measure moments. This makes it clearer when the employee is perceiving stress and what the reason is. For future research observations could be done. The observation gives the possibility to be close to the subject of interest in the natural setting (Brannen & Oultram, 2012). Looking at the tasks and time pressure which the employees experience could have given an extra impulse to the research.

Finally, the role of researcher in this study. Before conducting this research, I was already aware of the working conditions in the care sector. This is because my sister is working in the care sector, and she provided me with some stories. I also read lots of articles about COVID-19 in the care and the consequences of COVID-19. This included story of care workers. Besides this I have an opinion about the COVID-19 that this is a serious threat for everyone. With the knowledge that I gained in front of the research and my opinion about COVID-19 could have a possible impact on the way that I interpreted and coded the data, but also on how I asked some questions and gathered the data.

References

Achterbergh, J., & Vriens, D., (2019). Organizational development: designing episodic interventions. London: *Routledge*.

AD.nl (2020, september 29) *Nergens zoveel ziekteverzuim als in de zorg: werkdruk is hoog*. Retrieved from: https://www.ad.nl/werk/nergens-zoveel-ziekteverzuim-als-in-de-zorg-werkdruk-is-hoog~ab9bf8a8/

Adalja A.A., Toner E., & Inglesby T.V. (2020) Priorities for the US health community responding to COVID-19. *Jama 323*(14): 1343-1344.

Allen, M. W., & Caillouet, R. H. (1994). Legitimation endeavors: Impression management strategies used by an organization in crisis. *Communication Monographs* , 61(1), 44–62.

Anand, N., & Daft, R.L. (2007). What is the right organization design? *Organizational Dynamics*, 36(4), pp. 329–344.

Argyris, C., & Schön, D.A. (1978). Organizational Learning. Boston, MA: *Addison Wesley*.

Armitage, R., Nellums, L. B. (2020). COVID-19 and the consequences of isolating the elderly. *The Lancet Public Health*, 5(5), Article e256.

Aspers, P. (2018), Forms of Uncertainty Reduction: Decision, Valuation, and Contest. *Theory and Society* 47, pp. 133– 149.

Backman, A., Sjögren, K., Lövheim, H. & Edvardsson, D. (2018). Job strain in nursing homes-Exploring the impact of leadership. *J. Clin. Nurs.* 27, 1552–1560.

Bakker, B.A., Demerouti, E., De Boer, E., Schaufeli, W.B., Job demands and job resources as predictors of absence duration and frequency, *Journal of Vocational Behavior*, Volume 62, Issue 2, Pages 341-356,

Bakker, A. B., Demerouti, E., & Euwema, M. C. (2005). Job resources buffer the impact of job demands on burnout. *Journal of Occupational Health Psychology*, 10(2), 170-180.

Bakker, A. B., Demerouti, E. & Verbeke, W. 2004. Using the Job Demands-Resources model to predict burnout and performance. *Human Resource Management*, 43: 83–104.

Bakker, A. B., Schaufeli, W.B., & Demerouti, E. (1999). Werkstressoren, energiebronnen, en burnout:

Barnett ML, and Grabowski, DC (2020) Nursing homes are ground zero for COVID-19 pandemic. *JAMA Health Forum 1*(3).

Blatter, B., Houtman, I., Bossche van den, S., Kraan, K., Heuvel van den, S. (2005) Gezondheidsschade en kosten als gevolg van RSI en psychosociale arbeidsbelasting in Nederland. *TNO Kwaliteit van Leven*.

Bleijenbergh, I. (2015). Kwalitatief onderzoek in organisaties (2e editie). Amsterdam, *Boom Lemma uitgevers.*

Boin, A.& P. ‘T Hart (2007) The Crisis Approach. *In*: H. Rodríguez, E. L. Quarantelli & R. Dynes, eds., *Handbook of Disaster Research*, pp. 42– 54.

Boumans N.P.G., Berkhout A.J.M.B., Vijgen S.M.C., Nijhuis F.J.N., Vasse R.M. (2008). The effect of integrated care on quality of work in nursing homes: A quasi-experiment. *International Journal of Nursing Studies 45,* 1122-1136.

Brannan, M., & Oultram, T. (2012). Participant observation. In Symon, G. and Cassell, C. (eds), Qualitative Organizational Research (pp.296-313). Londen: *Sage*

Brinks, V., & Ibert, O. (2020). From corona virus to corona crisis: The value of an analytical and geographical understanding of crisis. *Tijdschrift Voor Economische En Sociale Geografie*, 111, 275– 287.

Brodaty, H., Draper, B., & Low, L. F. (2003). Nursing home staff attitudes towards residents with dementia: Strain and satisfaction with work. *Journal of Advanced Nursing*, 44(6), 583– 590.

Burke, R. J., & Greenglass, E. R. (1999). Work–family conflict, spouse support, and nursing staff well-being during organizational restructuring. *Journal of Occupational Health Psychology, 4*(4), 327–336.

Burke, R. J. and Greenglass, E. R. 2001. Hospital restructuring and nursing staff well-being: The role of perceived hospital and union support. *Anxiety, Stress and Coping*, 14: 93–115.

Burns, T., & Stalker, G.M. (1961). The Management of Innovation. Oxford, UK: *Oxford University Press.*

Carayon, P. (1993) A longitudinal test of Karasek's Job Strain model among office workers, *Work & Stress*, 7:4, 299-314.

Chong, V., & Monroe, G. (2015). The impact of the antecedents and consequences of job burnout on junior accountants' turnover intentions: a structural equation modelling approach. *Accounting & Finance*, 55, 105-132.

Christensen, C. et al. (2009). *The Innovator's Prescription. A Disruptive Solution for Health Care*. New York: *McGraw Hill*. Chapter 1-6, pp. 1-221.

Clegg, A. (2001). Occupational stress in nursing: A review of the literature. *Journal of Nursing Management*, 9(2), 101– 106.

Cohen M.A., Tavares J. (2020). Who are the most at risk older adults in the COVID-19 era? It's not just those in nursing homes. *Journal of aging & Social Policy.* 280-386.

Coombs, W. T. (2015). What equivocality teaches us about crisis communication. *Journal of Contingencies and Crisis Management* , 23(3), 125–128.

Deakin, H., & Wakefield, K. (2014). Skype interviewing: Reflections of two PhD researchers

De Sitter, L.U. (1994). Synergetisch produceren. Assen, The Netherlands: *Van Gorcum*.

De Sitter, L.U. (2000). Synergetisch produceren: Human resources mobilisation in de produktie: Een inleiding in structuurbouw (3rd ed.). Assen: *van Gorcum*.

De Veer A.J.E., Francke A.L., Poortvliet E.P., Eliens E. (2007) *Verzorgenden vinden zorg in verpleeg- en verzorgingshuizen steeds complexer. Nivel*. Retrieved from: https://www.nivel.nl/sites/default/files/bestanden/pvv279%20FactsheetComplexiteitinouderen zorg-def.pdf

Del Pozo-Antúnez, J., Ariza-Montes, A., Fernández-Navarro, F., & Molina-Sánchez, H. (2018). Effect of a Job-Demand-Control-Social Support Model on Accounting Professionals' Health Perception. *International Journal of Environmental Research and Public Health*, 15, 2437.

Dierendonck, D. van, Schaufeli, W. B. and Buunk, B. P. 1998. The evaluation of an individual burnout intervention program: The role of inequity and social support. *Journal of Applied Psychology*, 83: 392–407.

Dong L, Bouey J. (2020) Public mental health crisis during COVID-19 pandemic, China. *Emerg Infect Dis.*

Doordewaard, H., Kil, A. & Ven, A. van de (2015) het praktijkgerichte kwalitatief onderzoek. Amsterdam: *Boom Lemma uitgevers*.

Dubois, A., & Gadde, L. E. (2002). Systematic combining: an abductive approach to case research. *Journal of business research*, 55(7), 553-560

Edberg, A., Bird, M., Richards, D. A., Woods, R., Keeley, P., & Davis-Quarrell, V. (2008). Strain in nursing care of people with dementia: Nurses' experience in Australia, Sweden and United Kingdom. *Aging & Mental Health*, 12(2), 236– 243.

Edvardsson, D., Sandman, P. O., Nay, R., & Karlsson, S. (2009). Predictors of job strain in residential dementia care nursing staff. *Journal of Nursing Management*, 17(1), 59– 65.

Fagerberg, I., & Kihlgren, M. (2001). Registered nurses' experiences of caring for the elderly in different health-care areas. *International Journal Nursing Practice*, 7(4), 229– 236.

Fila, M. (2016). The Job Demands, Control, Support Model: Where are We Now? TKM International *Journal for Research in Management*, 1(1), 15-44.

Fischer, F., Raiber, L., Boscher, C., Winter, M. H. J. (2020). COVID-19 and the elderly: Who cares? *Frontiers in Public Health*, 8, Article 151.

Franzosa, E., Tsui, E. K., Baron, S. (2019). "Who's caring for us?": Understanding and addressing the effects of emotional labor on home health aides' well-being. *The Gerontologist*, 59(6), 1055–1064.

French, S., Lenton, R., Walters, V., & Eyles, J. (2000). An empirical evaluation of an expanded Nursing Stress Scale. *Journal of Nursing Measurement*, 8(2), 161– 178.

Galbraith, J.R. (1973). Designing Complex Organizations. Boston, MA: *Addison-Wesley*.

Gerritsen, D. L., & Oude Voshaar, R. C. (2020). The effects of the COVID-19 virus on mental healthcare for older people in the Netherlands. *International Psychogeriatrics*, 1–4.

Gioia, D. A., Corley, K. G., & Hamilton, A. L. (2013). Seeking qualitative rigor in inductive research: notes on the Gioia methodology. *Organizational Research Methods*, 16(1), 15-31

Giuliani, E., Lionte, G., Ferri, P., Alberto Barbieri, (2018) The burden of not-weighted factors – Nursing workload in a medical Intensive Care Unit,
Intensive and Critical Care Nursing, Volume 47, Pages 98-101,

Grabowski D.C, Mor V. Nursing Home Care in Crisis in the Wake of COVID-19. *JAMA*. 2020;324(1):23–24.

Hakanen, J. J., Bakker, A. B., & Schaufeli, W. B. (2006). Burnout and work engagement among teachers. *Journal of School Psychology*, 43(6), 495-513.

Holden R.J., (1991) Responsibility and autonomous nursing practice. *Journal of Advanced Nursing* 16, 398– 403.

Huotari, P., & Havrdová, Z. (2016). Stakeholders' roles and responsibilities regarding quality of care. *International journal of health care quality assurance*.

Jackson D., Bradbury-Jones C., Baptiste D., Gelling L., Morin K., Neville S., and Smith G.D. (2020) Life in the pandemic: Some reflections on nursing in the context of COVID-19. *Journal of Clinical Nursing 29(*13-14): 1-3.

Janssen, M., Van der Voort, H., Agile and adaptive governance in crisis response: Lessons from the COVID-19 pandemic, *International Journal of Information Management*, Volume 55,

Johnson, J.V., & Hall, E. M. (1988). Job strain, workplace social support, and cardiovascular disease. A cross-sectional study of a random sample of the Swedish Working population. *American Journal of Public Health and the Nations Health*, 78, 1336– 1342.

Jong Goon Ha , Ji Man Kim, Won Ju Hwang & Sang Gyu Lee (2013) Impact of organisational characteristics on turnover intention among care workers in nursing homes in Korea: a structural equation model *Australian Health Review 38*(4) 425-431.

Karasek, R. (1979). Job demand, job decision latitude and mental strain: implication for job redesign. *Administrative Science Quarterly*, 24: 285-308.

Karasek, R., & Theorell, T. (1990). Healthy work: Stress, productivity, and the reconstruction of working life. New York, NY*: Basic Books*

Kant I.J., Jansen N.W.H., Amelsvoort L.G.P.M. van, Mohren D.C.L., Swaen G.M.H. Burnout in de werkende bevolking. Resultaten van de Maastrichtse Cohort Studie. *Gedrag & Organisatie* 2004;17(1):5-17.

Klassen, A.C., Creswell, J., Plano Clark, V.L. *et al.* Best practices in mixed methods for quality of life research. *Qual Life Res* **21,** 377–380 (2012). https://doi.org/10.1007/s11136-012-0122-x

Korczynski, M., Shire, K., Frenkel, S., & Tam, M. (2000). Service work in consumer capitalism: customers, control and contradictions. *Work, Employment and Society*, 14(4), 669-687.

Kruse, F., Abma, I., & Jeurissen, P. (2020). *The impact of COVID-19 on long-term care in the Netherlands*. LTCcovid, International Long-Term Care Policy Network, CPEC-LSE. Retrieved from https://ltccovid.org/wp-content/uploads/2020/05/COVID19-Long-Term-Care-situation-in-the-Netherlands-25-May-2020-1.pdf

Kuipers, H., van Amelsvoort, P., & Kramer, E.-H. (2018). *Het Nieuwe Organiseren: alternatieven voor bureaucratie*: *Acco Leuven*.

Kusmaul, N., Beltran, S., Buckley, T., Gibson, A., Bern-Klug, M.. (2021) Structural Characteristics of Nursing Homes and Social Service Directors that Influence Their Engagement in Disaster Preparedness Processes. *Journal of Gerontological Social Work* 0:0, pages 1-16

Kuwahara, K., Kuroda, A., & Fukuda, Y. (2020). COVID-19: Active measures to support community-dwelling older adults. *Travel medicine and infectious disease*, *36*, 101638. https://doi.org/10.1016/j.tmaid.2020.101638

Lagergren, M. (2002). The systems of care for frail elderly persons: The case of Sweden. *Aging Clinical and Experimental Research*, 14(4), 252– 257.

Lev, S., Ayalon, L. (2018). Development and content validation of a questionnaire to assess moral distress among social workers in long-term care facilities. *Social Work in Health Care*, 57(3), 190–205.

Loe M. & Moore C.D. (2012) From nursing home to green house: Changing contexts of elder care in the United States. *Journal of Applied Gerontology* 31(6): 755-763.

Lucchini A., Lozzo P., Bambi S. (2020) Nursing workload in the COVID-19 era *Intensive Crit Care Nurs. doi: 10.1016/j.iccn.2020.102929*

Lopez S.H. (2006) Emotional labor and organized emotional care: Conceptualizing nursing home care work. *Work and Occupations 33*(2): 133-160.

Manz, C. C., & Grothe, R. (1991). Is the work force vanguard to the 21st century a quality of work life deficient-prone generation?. *Journal of Business Research*, 23(1), 67-82.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). Maslach burnout inventory manual. Palo Alto, CA: *Consulting Psychologist Press*

McGilton, K. S., Hall, L. M., Wodchis, W. P., & Petroz, U. (2007). Supervisory support, job stress, and job satisfaction among long-term care nursing staff. *The Journal of Nursing Administration*, 37(7–8), 366– 372.

McVicar, A. (2003). Workplace stress in nursing: A literature review. *Journal of Advanced Nursing*, 44(6), 633– 642.

Mintzberg, H. (1980). Structure in 5's: A Synthesis of the Research on Organization Design. *Management Science*, *26*(3), 322-341.

Mohr, B. J., & Dessers, E. (2019). Designing from a socio-technical systems perspective. In *Designing Integrated Care Ecosystems* (pp. 25-48): Springer.

Moorkamp, M., Torenvlied, R., & Kramer, E.-H. (2020). Organizational synthesis in transboundary crises: Three principles for managing centralization and coordination in the corona virus crisis response. *Journal of Contingencies and Crisis Management*, 28, 169– 172.

Morgan, G. (1986). Images of Organization. London: SAGE

Morgan, D. G., Semchuk, K. M., Stewart, N. J., & D'Arcy, C. (2002). Job strain among staff of rural nursing homes. A comparison of nurses, aides, and activity workers. *Journal of Nursing Administration*, 32(3), 152– 161.

Munyisia, E. N., Yu, P., & Hailey, D. (2011). How nursing staff spend their time on activities in a nursing home: an observational study. *Journal of Advanced Nursing, 67*(9), 1908-1917.

Myers, M. D. (2009). Qualitative Research in Business & Management (2nd ed.). London, SAGE Publications Ltd.

Neto M., Almeida H.G., Esmeraldo J.D., Nobre C.B., Pinheiro W.R., de Oliveira C., Sousa I., Lima O., Lima N., Moreira M.M., Lima C., Júnior J.G., da Silva C. (2020) When health professionals look death in the eye: the mental health of professionals who deal daily with the 2019 coronavirus outbreak. Psychiatry Res 288:112972. *Advance online publication*.

NOS.nl (2020, januari 6) Nu ook in het noorden dramatische verhalen uit verpleeghuizen. Retrieved from: https://nos.nl/artikel/2363251-nu-ook-in-het-noorden-dramatische-verhalen-uit-verpleeghuizen.html

Nursing. (2013, October 25). *"*Werkdruk in verpleeg- en verzorgingshuizen te hoog.*"* https://www.nursing.nl/werkdruk-in-verpleeg-en-verzorgingshuizen-te-hoog-1396812w/

NU.nl. (2018, December 17). Werkdruk in de zorg: "Wat vroeger druk was, is nu heel normaal.*"* NU. Retrieved from: https://www.nu.nl/werk/5630798/werkdruk-in-zorg-wat-vroeger-druk-was-heel-normaal.html

OECD (2009). The long-term care workforce: Overview and strategies to adapt supply to a growing demand. Retrieved from http://www.oecd.org/els/health-systems/long-termcareworkforceoverview.html

Orrung Wallin, A., Jakobsson, U., & Edberg, A. K. (2015). Job strain and stress of conscience among nurse assistants working in residential care. *Journal of Nursing Management*, 23(3), 368–379.

Parker, C., Barnes, S., McKee, K. et al. (3 more authors) (2004) Quality of life and building design in residential and nursing homes for older people. *Ageing and Society*, 24 (6). pp. 941-962.

Parkes, K. R. 1989, Personal control in an occupational context, in A. Steptoe and A. Appels (eds), *Stress, Personal Control, and Health* (Wiley, Chichester), 21-47.

Pavlish, C., & Hunt, R. (2012). An exploratory study about meaningful work in acute care nursing. *Nursing forum*, 47(2), 113-122.

Perkewe, P. L. and GANSTER, D. C. 1989, The impact of job demands and behavioral control on experienced job stress, *Journal of Organizational Behavior*, 10, 213-229.

Perry, T.E., Kusmaul, N., Halvorsen, C.J., (2020) Gerontological Social Work's Pivotal Role in the COVID-19 Pandemic: A Response from AGE*SW* Leadership. *Journal of Gerontological Social Work* 63:6-7, pages 553-558.

Pless, S., Dessers, E., & Van Hootegem, G. (2016). Organisatiemodellen voor geïntegreerde zorg. Probleemanalyses en-oplossingen vergeleken van Klinische Zorgpaden, Lean, *Relationele Coördinatie en Moderne Sociotechniek.*

Prins, J. T., Hoekstra-Weebers, J. E. H. M., Gazendam-Donofrio, S. M., Van De Wiel, H. B. M., Sprangers, F., Jaspers, F. C. A., & Van der Heijden, F. M. M. A. (2007). The role of social support in burnout among Dutch medical residents. *Psychology, Health and Medicine*, 12(1), 1–6.

Rodney, V. (2000). Nurse stress associated with aggression in people with dementia: Its relationship to hardiness, cognitive appraisal and coping. *Journal of Advanced Nursing*, 31(1), 172– 180.

Said, R.M., El-Shafei, D.A.(2021) Occupational stress, job satisfaction, and intent to leave: nurses working on front lines during COVID-19 pandemic in Zagazig City, Egypt. *Environ Sci Pollut Res* 28, 8791–8801.

SALAR (Swedish Association of Local Authorities and Regions) (2009). Developments in elderly policy of Sweden. Retrieved from http://webbutik.skl.se/sv/artiklar/developments-in-elderly-policy-in-sweden.html

Schaufeli, W. B., Bakker, A. B., & Salanova, M. (2006). The measurement of work engagement with a short questionnaire a cross-national study. *Educational and Psychological Measurement,* 66(4), 701-716.

Schaufeli, W. B., & Bakker, A. B. (2004). Job demands, job resources, and their relationship with burnout and engagement: A multi-sample study. *Journal of Organizational Behavior*, 25(3), 293-315.

Schaufeli, W. & Dierendonck van, D. (2000). Utrechtse Burnout Schaal UBOS, handleiding (Utrecht Burnout Scale Manual), Utrecht: *Swets en Zeitlinger*.

Schaufeli W, Houtman I. (2000) Psychische vermoeidheid en werk. In: Psychische Vermoeidheid en Werk: *Cijfers, Trends en Analyses*. Alphen a/d Rijn: Samsom.

Shahar, I., Asher, I., Ben Natan, M. (2019). Compassion fatigue among nurses working in a long-term care facility: The Israeli experience. *Nursing & Health Sciences*, 21(3), 291–296.

Shenjiang Mo, Junqi Shi (2020) The Psychological Consequences of the COVID-19 on Residents and Staff in Nursing Homes Work, *Aging and Retirement*, Volume 6, Issue 4, October 2020, Pages 254–259.

Smith, A. (1977). Wealth of Nations. Chicago, IL: *Chicago University Press*

Michael Simon, Angelika Kümmerling & Hans-Martin Hasselhorn (2004) Work-Home Conflict in the European Nursing Profession, *International Journal of Occupational and Environmental* Health, 10:4, 384-39.

Sjöberg, A., Pettersson-Strömbäck, A., Sahlén, K. G., Lindholm, L., & Norström, F. (2020). The burden of high workload on the health-related quality of life among home care workers in Northern Sweden. *International Archives of Occupational and Environmental Health*, 1-18.

Skår, R. (2010). The meaning of autonomy in nursing practice. *Journal of Clinical Nursing*, *19*(15–16), 2226–2234.

Stall, N.M., Farquharson, C., Fan-Lun, C., Wiesenfeld, L., Loftus, C.A., Kain, D., Johnstone, J., McCreight, L., Goldman, R.D. and Mahtani, R. (2020), A Hospital Partnership with a

Nursing Home Experiencing a COVID-19 Outbreak: Description of a Multiphase Emergency Response in Toronto, Canada. *J Am Geriatr Soc*, 68: 1376-1381.

Subramanian, D., & Suquet, J. B. (2018). Unpacking the service triangle: Arranging power relations between frontline occupations. *Work and Occupations*, 45(1), 38–81.

Symon, G., & Cassell, C. (2012). Assessing qualitative research. In G. Symon & C. Cassell 56 (Eds.), Qualitative organizational research: Core methods and current challenges (204-223). Los Angeles: *SAGE*.

Thompson, J.D. (2007, fifth printing). *Organizations in Action. Social Science Bases of Administrative Theory*. Part I, pp. 1-83.

Valackienè, A., and R. Virbickaitè. (2011). Conceptualization of crisis situation in a company. *Journal of Business Economics & Management* 12 (2): 317–331.

Van der Roest, H. G., Prins, M., van der Velden, C., Steinmetz, S., Stolte, E., van Tilburg, T. G., & de Vries, D. H. (2020). The impact of COVID-19 measures on well-being of older long-term care facility residents in the Netherlands. *Journal of the American Medical Directors Association*, *21*(11), 1569-1570.

Verbeek, H., Gerritsen, D. L., Backhaus, R., de Boer, B. S., Koopmans, R., & Hamers, J. P. H. (2020). Allowing visitors back in the nursing home during the COVID-19 Crisis: A Dutch National Study Into First Experiences and Impact on Well-Being. *Journal of the American Medical Directors Association*, *21*, 900–904.

Verbeek, H., Zwakhalen, S. M., van Rossum, E., Kempen, G. I., & Hamers, J. P. (2012). Small-scale, homelike facilities in dementia care: a process evaluation into the experiences of family caregivers and nursing staff. *International journal of nursing studies, 49*(1), 21-29.

Vermeerbergen, L., McDermott, A. M., & Benders, J. (2020). Managers shaping the service triangle: Navigating resident and worker interests through work design in nursing homes. *Work and Occupations*, 0730888420930770.

Vermeerbergen, L., Pless, S., Van Hootegem, G., & Benders, J. (2018). From silos to cells: Reducing repetitive jobs through sociotechnical redesign. *Economic and Industrial Democracy*, 0143831X18756758.

Vermeerbergen, L., Van Hootegem, G., & Benders, J. (2016). Putting a band-aid on a wooden leg: A sociotechnical view on the success of decentralisation attempts to increase job autonomy. *Team Performance Management*.

Visser, M., Schouteten, R., Dikkers, J. (2019). Controlling the Courts: New Public Management and the Dutch Judiciary. *Justice System Journal*, p. 1-15.

Viswesvaran, C., Sanchez, J. I., & Fisher, J. (1999). The role of social support in the process of work stress: A meta-analysis. *Journal of Vocational Behavior*, 54(2), 314– 334.

Wallenburg, I., & Helderman, J.-K. (2020). *The Netherlands response to the coronavirus pandemic [Cambridge Core blog post]*. Retrieved from https://www.cambridge.org/core/blog/2020/04/06/the-netherlands-response-to-the-coronavirus-pandemic/

Warr, P. B. (1987), Work, Unemployment, and Mental Health. *Oxford University Press*, Oxford.

Weick, K. E. (1988). Enacted sensemaking in crisis situations. *Journal of Management Studies* , 25, 305–317.

Winnubst, J., Schuur, F., & Dam, J. (1999). Praktijkboek gezond werken. (pp. 1-19). Amsterdam: *Elsevier*.

Elizabeth M. White, Terrie Fox Wetle, Ann Reddy, Rosa R. Baier, (2021) Front-line Nursing Home Staff Experiences During the COVID-19 Pandemic, *Journal of the American Medical Directors Association*, Volume 22, Issue 1, Pages 199-203.

World Health Organization . (2020). Coronavirus disease 2019 (COVID-19): Weekly epidemiological update. https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200907-weekly-epi-update-4.pdf?sfvrsn=f5f607ee_2

Yin, R. K. (2014). Case study research: design and methods. London, *SAGE Publications*, Inc.

Yvonne Rafferty , Ronald Friend & Paul A. Landsbergis (2001) The association between job skill discretion, decision authority and burnout, *Work & Stress*, 15:1, 73-85.

Appendix

Appendix 1: Interview guide

Introduction

- The interview will last 30/45 minutes and requires no preparation;
- It will be recorded (only with your permission) for later transcribing.
- During the interview, aspects will be discussed that influence the perceived quality of work (possible stressors and the possible ways to deal with these stressors) and the tasks you perform as an employee.

- The interview will be anonymous and therefore cannot be traced back to you. The recording is for me only and the transcript will only be shared with my supervisor. This data is therefore only for research purposes;
- After transcribing, I will send you the transcript so that you can check whether I have interpreted it correctly and whether it contains sensitive information that you do not feel comfortable with afterwards.
- You can withdraw at any time, so participation is completely voluntary.
- Because of COVID-19, the interview will be conducted digitally via a platform of your choice.

Questions:

- What is your function?
- Tell a narrative story, target is around 10 minutes. Share your experiences during COVID-19. I will ask the broad question **"how are your work experiences during COVID-19?".** Just talk about it and I will make notes to prepare follow up questions.
- Possible follow up questions:
        - What was the most challenging and why?
        - What did you learn?
        - What about additional tasks because of COVID-19?
            - How are they divided?
            - To what extend do you have control over this?
        - What about the measures because of COVID-19?
            - How, what and why are these measures there?
    - How is it to be near to the fire, and the possibility to take the virus home?

Karasek:

- Time pressure
    - What about the time that you have to complete tasks?
- Autonomy
    - What about the autonomy that you have to make your own decisions?
        - Why is that?
- Task variation
    - What about the task variation in your job?
        - What is the reason?
- Emotional exhaustion
    - What about emotional exhaustion because of COVID-19?
- What about the role of your family, peers, residents and residents' family in your job?

De Sitter

- What tasks do you perform during your work?
- Can you indicate how the tasks are divided?
- How do you work?
    - With whom?
    - Which patients do you visit?
        - Does this change?
    - What are the advantages and disadvantages of this approach regarding COVID-19?
- How did you deal with COVID-19 in terms of policies?
- What is your opinion about giving care in a homelike environment?

- Does it give more connection?
- How is this right now, during COVID-19?
    - Do you feel that you are more connected with the patient and that depletion is harder to see for you?

Appendix 2: First contact mail

Dear,

My name is Nick Oosting, I am 24 years old, and I have recently started the final phase of my Master of Business Administration. For my Master Thesis of the Organizational Development & Design program, specialization of the Master of Business Administration, I want to research the effect of the organizational structure of nursing homes on the quality of work of the caregivers during COVID-19. Currently, COVID-19 is gripping society and many nursing homes are suffering from COVID-19 infections among their residents. These infections and the pandemic bring about extra measures, these measures can affect the organizational structure and thus the quality of work for the caregivers. In my Master Thesis the COVID-19 pandemic is seen as a 'crisis situation'. During the research I want to look at how the nursing home reacts to the crisis situation in the form of organizational changes (or no changes) and what effect this has on the quality of work. To conduct my research, I want to make a comparison between two cases. The first case is a nursing home with relatively low COVID-19 numbers and the second case is a nursing home with relatively high COVID-19 infections.

What does participation entail?

For the research I need 8 to 10 interviews at both cases, the interviews will take plus minus one hour. It requires very little preparation and therefore the effort for the interviewee will be limited to one hour. The interviews will take place in mid-April and will be digital. The information will be kept confidential and will only be used for research purposes. Names and other confidential information will be anonymized so that nothing can be traced. If there are any wishes from the organization I can include them in my research. After completion of the research the report will be shared with you, containing my findings. If there are any questions before participating, you can always email or call me using the information below.

I am very excited to conduct my research! I hope you have the same and I may do the research with you. I would like to present my Master Thesis orally.

Enthusiastic greetings,
Nick Oosting

Appendix 3: Data structure

Quotes	**1st order**	**2nd order codes**	**3rd order**
We have after a time we just said okay this is for us no longer to do. Also, in terms of work, there was too much work in too short a time and also the sick people, with people who were still reasonable self-directed and independent we said: you get help with showering 3 times a week, we bring that back to 1 time. Making beds is not done in the morning, but when family comes you can ask your family, so we have put a lot of tasks, care back in the hands of people. (Respondent 3)	Extra tasks causing to scale down care	Scaling down care	Changes because of COVID
Of course, from a to z we have people here. With their own past, with their own carrying capacity and also different syndromes along with that. Some people sweat a lot, for example, someone with Parkinson's disease sweats every day. And it's not nice that you get help with washing once a week, washing was still done. But with showering at the moment, you wake up every morning wet in your bed from the urge to move and the sweating of the disease that comes with it, then you find it nice to be showered. When it's hot with the clinical picture, it helps a lot, so you actually start weighing up the consequences against each other, like, okay, with this person, we can reduce the showering and making the bed. (Respondent 2)	Looking which care can be scaled down		

That's very simple your other work that you actually come for that will be made narrower. This means that you become a little easier, that you start scaling down. Euhm... because someone likes to take a shower three times a week, it's just reduced to once a week. And euhm.. yes euhm that's what I found difficult. Because euhm also that you deprive people, and you deprive them just a lot. (Respondent 1)	Tough feeling about scaling down care		
Yes sort of we have team A and team B which are separated by a bridge in the middle basically. And team A provides care on the left side (A) and team B provides care on the right side (B) in that way you have to see it. Well within the residential care center, of course, a lot of clubs have been formed over the years. People have contact, sometimes people have family living here who live on side A and B and just to isolate the contamination of side A we also said people just don't have contact with each other. (Respondent 3)	Isolating part, A and part B to prevent COVID spreading	Measures to prevent spreading	
Well on an apartment what's it called then went a regular staff member who actually worked all day. And not what's it called and then in the morning they tried to send as many people there as possible. Yes. (Respondent 9)	One employee visited the COVID patient through the day		
Yes at one point we then of course had ourselves the period people who had corona. Then you do try to put them in one route so that the same people go there and not different ones each time.	Trying to put COVID patient into one route		

That you do have the same people going to that person. (Respondent 12)			
Yes... we then have three cases euhm of COVID and euhm I thought in principle that Livio did handle them well but at the first lockdown I did think that she euhm (Respondent 13)	Three COVID cases in the location	COVID infections residents	
With us is of well if you start then at the testing itself, weird cough, long time diarrhea, fever, low saturation. Immediately packed in and a nurse who does the test. And usually, we walk the nurse with us, so you actually do the test together. Then on the door on the outside there will be a sticker that says quarantine. That doesn't immediately mean they're COVID positive. Then we and the residents know that there is a COVID risk. It has happened to us that family members say, "Oh, I've been here, but I have a cold and I'm going to get tested. Then we wait and see what the test shows. And then it's just wait 48 hours and um sometimes earlier when you have the results. And if it's positive then not many changes. It's just extra care to see that it doesn't get any worse, you know, that the resident doesn't get more complaints and things like that. (Respondent 12)	Positive COVID case in quarantine		
There is a quarantine sign, and the neighbors know that they should not go inside. But sometimes it is very difficult because some people just leave their apartment. Yes, they are demented, and they have no idea what they are doing	Sign on the door to show that COVID is there		

and fortunately these were the people who were not what's-her-name who turned out to be negative later on. But the people who were positive yes they really stayed in their apartment. (Respondent 9)			
And if you then have to do the service, the normal care with the care for the people who have COVID with all the measures, quality requirements, well increasing care requests that you have in combination with a shortage of staff and an increasing demand for care, it became a bit busy. And that was reflected in the fact that we were working overtime, some colleagues were home for a week, some for a month. (Respondent 3)	Infected colleagues cannot work	COVID infection colleagues	
There was yes there was definitely less staff and sometimes, what's the name of that were they working, because we have to even if you were tested you had to work. Then one of them would come in and say yes, I have to go home, I'm positive, okay. Well, he would drop everything and then someone else would have to pick up on it, that's okay because we're all doing it together, it's all going fine. (Respondent 9)	Less employees because of COVID infection		
And that's where it started to roll, and in the end, so much of our team 80% of the colleagues unfortunately had the virus. And that meant at those moments that the workload of the other colleagues increased enormously. (Respondent 1)	Most of the colleagues are infected with COVID-19		
Yes, definitely. That need is there uber-well, outside of COVID already. It's just becoming more so now, it's uncertain of	C&C is more needed because of COVID	Decision during COVID	

course. We all know how things have gone recently in the Netherlands, it's uncertain for everyone. And not is clear, policy is often vague too. Or doesn't match your feelings because it's a little bit below that. And then you just need someone to make very clear decisions and make policy. (Respondent 14)			
The organization has a CCT which is a corona coordination team so to speak. And in it are MT members and they discuss, say, the trend in the country, but also the relaxations that are agreed upon nationally and they discuss that within that team, the CCT. So that's where decisions are made about policy within the organization. And we as the C&C always receive the minutes and then on every Wednesday at 09.00 there is an hour of question time for the C&C. So, in which announcements are made, but also questions can be asked regarding policy. In principle, we can also communicate this within the location and also take questions back to that question time, and in addition to that, on a minework there is a heading for current corona policy, all the policy documents and rules are listed. (Respondent 14)	CCT make COVID policy		
The organization has a CCT which is a corona coordination team so to speak. And in it are MT members and they discuss, say, the trend in the country, but also the relaxations that are agreed upon nationally and they discuss that within that team, the CCT. So that's where	Only RVE managers in CCT		

decisions are made about policy within the organization. And we as the C&C always receive the minutes and then on every Wednesday at 09.00 there is an hour of question time for the C&C. So, in which announcements are made, but also questions can be asked regarding policy. In principle, we can also communicate this within the location and also take questions back to that question time, and in addition to that, on a minework there is a heading for current corona policy, all the policy documents and rules are listed. (Respondent 14)			
No, we have so said every resident has an apartment well and then that gets very complicated if I'm going to explain that to you completely. So, we have people who rent an apartment, we don't do that. Then you have people who rent, and they have a home care indication. Well that either comes from an external home care or we fulfill that indication as care staff. They often have housekeeping from outside, so they hire someone themselves. And then you have the people who have a residential care indication. In addition, it is already so that you euhmm people euh also offer the food and euhm the laundry can do euhm the household work euhm and for that we have a facility service, a guest service. And so, they walk with us in the grand cafe who take care of the housekeeping part and then a resident chooses for example whether the daughter does the	All types of residents are mixed up in the location which causes complexity	Resident structure	Organisational structure

laundry or that we do it. An amount is then charged for that. And when someone has an indication for the nursing home, they can still live with us but then everything is included in that package. And then we have to offer that as well, so then, um, I can say to my care workers, okay, if the laundry comes in washed and ironed, you can put it in the closet. But if it's a residential care resident then um, sometimes we're not even allowed to put it further away than that you put it on the bed or then the family has to put it in the closet. (Respondent 7)			
We have the first floor, first, second and third floor during the week the staff changes. We do see different people, so you see the same people always see the same people, no that's not true. (Respondent 3)	Care workers see other residents every day		
Everything is mixed up here. We have home care clients here, and we have WLZ residents here with treatment and we have WLZ residents here without treatment and actually in one route here everything is mixed up which by the way is not my preference, but that is what is going on here to date. (Respondent 14)	The residents are not divided on the basis of the care they need		
Well, I'm mostly always about working together. And being low key and making decisions together, but if a decision is not made then I make it so to speak. So, I always try to put things back in the team to make a decision together with them and let them think along with me and	C&C makes decisions when nobody else does	Decision structure	

make decisions together. But if that doesn't happen then I make the decision. And I am in that respect also when it comes to quality policy and all that kind of stuff. (Respondent 14)			
Actually, that's euhm it's just at a certain point when there's no more family coming then the care team is the first to see what tasks remain. And then you consult with each other and if it's too much for us, then we go and talk to the coach coordinator. That's actually during the consultations on Tuesday you go back into discussion this is now with us and we can't carry this. And asking what support can be done and then we start sparring together again on how we can give this shape and then an answer came, and we continued in this way. (Respondent 1)	Coordinating their own tasks		
Yes, that went happily. And from home, of course, they can do a lot. So, then you did a lot over the phone and things like that. But the most important thing of course, the care, that if they were not very sick they were allowed to go back to work after 10 days. That wasn't too bad. (Respondent 12)	Coordination of tasks done within the team		
I think that when it comes to changing policy I think they should consult with me first. Then he is very something operational that fits within the policy. We use I don't know, call something simple euhm then I think that self care professionals know how to do it best, so you have to decide that yourself. When it	COVID policy changes needs to be discussed with C&C		

comes to protocols, guidelines and policies, for example the corona policy that is organization wide. Then I don't think they can make a decision on that themselves, without consulting me. (Respondent 14)			
If the toilet is dirty we as a care worker all clean the toilet, all wash the dishes and all take the trash. We basically see as a nurse your job is to see them all (Respondent 1)	Doing the dished and cleaning the toilet	Task structure	
So, for example, if you have the role or task of employee, then there are two employees in the team who ensure that if there is a vacancy, it is filled. For example, in the beginning when I came they did the job interviews themselves, but I felt that they lacked some quality. So, um... now we often do all the interviews um... together. And if there are still doubts, we then have a 'click' meeting with two employees to find out whether someone really fits into the team, so they do have some influence on who joins their team, for example. (Respondent 7)	Influence on the recruitment process		
The care became euhm became heavier he because you already what you just say with that mouth mask and being alert he on people who have complaints and take them seriously and normally you have something like a cough. And then a cough was really an alarm so yes you are much more focused on euhm yes what is actually normal with euhm... looking also	More alert for small complaints		

at I can't put it into words, observing and so on you know. (Respondent 2)			
No, no that's new to me too. Here they actually only have nursing IGers and some nurses, but mainly nursing IG and no aides. That was also new to me, so. In a route like this, the IG just does everything. If he is with a client, he gets him out of bed, washes him, dresses him, makes a sandwich, empties the bag from the trash. So, he actually does the whole picture. (Respondent 14)	Nurses and care workers perform the same tasks		
A nurse IG, that is a nurse IG 3 who euhm... does for example euhm.. euhm... help people with a hoist with the mobility euhm medication euhm.. also wound treatment and the like. Erm... level 4 is sometimes just a bit more complex when you're talking about erm... technical action, which is allowed just a bit more when you're talking about flushing the bladder, changing a catheter and things like that. But at level 5 we don't have that many people in the residential care center who are allowed to do the indications. (Respondent 7)	Nurses level 4 and nurses level 5 have more authorizations		
Well under the operation role that also includes a piece of planning. And that, that colleague plants but say colleagues. The planning consists of three rounds. In the first round, colleagues can complete their grid. In round two, the planner is then looked at, returning or it corresponds. Then there is still room to adjust services. In the final round it is definitively made by the planner. The	Planning is part of every care team		

planner is therefore someone who has the role of business operations. (Respondent 14)			
Well within Livio they don't talk about self-direction, but they do talk about professional organized teams. We have team roles in this, quality employee, management and client. And they have divided these, so to speak, as tasks within the team into roles, so euhm... employees have looked for themselves what I find interesting. (Respondent 7)	Tasks within team roles in a self organising team		
Well, the 'nice day' employee actually takes care of what the name implies, extra attention, and they're not so, so busy with basic care. They really, they really give a little extra attention, so an errand with the people, individually a game, individually with the people. They also support the eating group, so to speak. We have a group where people eat who are no longer able to do so themselves. They are really mainly active in the field of welfare and extra attention. (Respondent 14)	Nice day worker is there for the extra attention of the residents	Team structure	
Well under the role of business management that includes a piece of planning. And that, that colleague schedules say colleagues. The planning consists of three rounds. In the first round, colleagues can fill in their own schedules. In the second round, the planner looks at it and returns whether it matches. Then there is still room to adjust shifts. In the last round, the planner makes the final decisions. The	Planning is part of every care team		

planner is thus someone who has the role of business management. (Respondent 14)			
Euhm... well and so those tasks are all distributed among the staff that are on a team so there are often two staff members who are responsible for the schedule, for the planning there are people who look at the budget, are our rooms all occupied. The moment that's no longer an issue. Are they going to look at do we put in a new type of staff? (Respondent 14)	Team in charge of budget, planning and room occupancy		
And the planners do base on the services they plan the routes. They do that based on the tickets that are created. So, suppose you have one day shift and two short morning shifts. Then three routes have been written down and these routes are filled with the tickets and that is basically what the planning does, but the nurse can make adjustments if necessary. This sometimes happens if something comes up in between, or if something has been added or removed, then this is sometimes adjusted. (Respondent 14)	Team planners plan the routes		
Euhm... well actually we have the function nurse IG, and the nurse level 4 and the nurse level 5. Euhm... nothing else indeed. (Respondent 7)	Three different skilled types of care worker in one team		
home is home and that was also for me a piece of rest and relaxation to be able to continue the next day. I think there is quite euhm there is quite often said to me, also at home. I have a lot of respect for you that you can do this work. I	Feeling supported by their family	Family support	Social support

would not be able to do this, they said. I think there was a lot of understanding in the environment of how the work was for us at that time. (Respondent 1)			
That is difficult yes groceries and euhm.. packages are brought and put on the driveway. Neighbors who called every day if they could do something for us, yes really sweet. Everyone wants to help. (Respondent 2)	Support from family and friends during the positive COVID period		
Yes I have to say my sisters all work in the care sector too yes. There has been a lot of calling I must say hey with each other how are you doing there. And and still erase things that maybe could be easier and what we can learn from each other. (Respondent 2)	Talking with sister who also work in the care sector		
Well then I became very demotivated. Then I thought what am I actually doing it for. (Respondent 9)	Demotivated because family break the rules	Negative contact residents family	
Apart from the fact that it just has a very negative impact and that it demotivates you to work it's just energy consuming and time consuming. The time that you actually spent on people like that and also just have to spend with all due respect to be able to prevent escalation could have been used very well to provide care for the people who needed it at that moment. (Respondent 3)	Negative contact with family is time consuming		
At one point you feel more like a police officer than really paying attention. Is there family, is there not too much family, are they following the rules. So instead of being there for the residents	On a point feeling more a cop than care worker		

themselves you're more playing police officer. (Respondent 12)			
on the one hand it was very calming there was an arrangement with the family that they could call between 11.00 and 14.00 or so for information. And those questions say all and rest of the times the staff have to be left alone, to deliver the care. (Respondent 2)	Peaceful that the family was not around		
And euhm and I also had a run-in with a resident's sun once. Who then also berated me and everything on Facebook. So, it was not really pleasant. There was Police and everything. (Respondent 9)	Threatened by residents family		
Yes I had a lot of support from colleagues. We were all there for each other though. As soon as someone was sick or something, the shifts were filled very quickly. (Respondent 12)	Colleagues giving strength	Peers support	
So yes, that's what I learned from it and yet, with your team, you came out very strong and you know very well what you have in common. And how it all stands. (Respondent 2)	Strong team		
Because you just notice those 5 colleagues were back within a week. The occupation was just needed. You don't have much choice in it. Because there are, however, silly because when I was sick, I may be sick. And at the time you come back then there is another colleague so that may also be sick, so you have to wear that with each other. (Respondent 1)	Supporting their colleagues		

How did I experience that? Um... it has also given us a lot of strength. It has also shown us that we have a really cool team that can carry a lot of weight. (Respondent 1)	Working in a team which give strength to go to work		
That does make me proud, that's what you do it for. Especially when you see that we had so few infections. That's what you do it for. (Respondent 12)	Appreciation makes her proud	Patient/family support	
That is super! I really felt enormously supported by that and that also means that you can increase the willingness of family, which means that if you ask them something now, I think that it builds up quite a credit. The contacts have really become stronger. In the majority of families. (Respondent 1)	Feeling supported by the residents family		
I say sometimes they are very simple things but when you make an image phone call and the family is radiant at the other end and very happy that you took the time to do that, yes, that really gives you strength. Then you really hang up with a feeling that you think how nice it is that I was able to do this for the family. That the family could talk with mother or father. So yes euhm... that certainly gave strength! (Respondent 1)	Seeing the residents and residents family happy gives strength		
Good communication is important for nice work environment (could be better) (ESS)	Good communication is important for nice work environment (could be better)	Communication	
Yes we the guideline was there but it was more purely directed to the family, and it changed so often that at one point the family members and the residents no	Fast changing policies		

longer knew what was allowed and what was not. (Respondent 13)			
Yes that they didn't follow the rules so with some they made an exception and with others they didn't. One family was not allowed inside, and the other was allowed inside. For example, one family was not allowed to enter, and another family was allowed to enter, but there were construction workers who were allowed to enter, so it was a bit confusing as to what was allowed and what was not. Erm... yes... yes... apart from that I thought it was actually quite good. (Respondent 13)	Inconsistent policy of the organisation		
And it was just not clear we had no frameworks, no policy for that. Even as an organization we had to search very hard for that and the policy sometimes changed by the week and at the beginning of last year when at the beginning yes, at the very beginning of the corona period so what we knew from that second period we already knew a lot more, there was something on paper and we knew how to act very quickly when something happened. (Respondent 7)	No clear guidelines		
In the beginning it is even more stressful, because family members have a lot of questions. But we also have the same questions, which you cannot answer to yourself, but not at all to your family. And that is of course very frustrating for the family. They want to know where their father or mother ends up. It is very	Not giving answers causes stress		

frustrating for them. Yes, it is. (Respondent 11)			
And I think in the organization you also had a lot of chaos. But also, a lot of gray areas. We as a team, we were quite critical of a lot of things and a lot of questions that hadn't actually come up before. Then you notice that the gray area despite the fact that so much is known that not every question has been asked yet. And at a time when you don't have an answer to that, it's very annoying. You just have to act now, it's an acute situation and what are we going to do? (Respondent 3)	Gray areas, not much known about COVID	Uncertainty	Job demands
In the beginning mainly hectic. Because you don't know what it is, what can you expect, where are we going, how long it takes. So, the beginning was a large chaos. You will hear this this is no longer allowed, that is no longer allowed to know anymore. Everyone has questions that you can actually answer anything because you don't know anything yourself. Yes the work leads underneath. You may no longer work with you. Yes what should you do? Family wants to come by but is not allowed. How do you go to work in terms of things that family always did for the residents, you should do all work. And how do you suddenly divide that. (Respondent 10)	Not knowing what is going to happen		
Yet it kept spreading so that was a piece of euhm... frustration of that yes but now we are getting it under control again and that I found euhm... you have completely	Unable to get grip on the COVID spreading		

lost the ship and then you really start doubting of what are we not doing right, are we not doing it right? (Respondent 1)			
In the beginning it is even more stressful, because family members have a lot of questions. But we also have the same questions, which you cannot answer to yourself, but not at all to your family. And that is of course very frustrating for the family. They want to know where their father or mother ends up. It is very frustrating for them. Yes, it is. (Respondent 12)	Uncertainty causes stress		
And our feeling did indicate at the beginning we are actually yes not running around like a chicken without a head, but it would have been nice if we had the information that we have now. That we actually had it available at the time. (Respondent 3)	Working while not knowing what to do		
At home you have to be careful, and you can't do anything. I call it but it is tackled, that's not the right term but I still use it. You can't spend more so much, leisure. It is precisely what you need to reduce your stress level was actually no longer possible. (Respondent 3)	Less relaxation because of restrictions in private life	Private balance	
That alertness euhmm... remains. And it gives quite a lot of tension I must say, and you take it home and of course you talk a lot about it. (Respondent 2)	Take work to home		
I wasn't ready when I got home from work, because then I had to get on with the planning. That was a very euhm... busy period and you pass by everything, so you are only busy with that and at a	Taking work home		

certain moment someone has to say to you yes, you have to take a step back. (Respondent 2)			
Well, um, yes, um, what would I say? My mother what's-her-name had an accident, and she got an open leg as a result and yes she's already difficult to walk but I had to take care of her for more than half a year. Actually, I came from work and I went there and I went home and then I was cooking and then I went back to work, sleep, work. And it was at one point yes I did run into a bit of a snag at home. I live alone with my daughter but that all went well. (Respondent 9)	Tough private balance		
I did have trouble with it for a few days before the switch. I thought it was all a bit soppy. For me it was all just a bit too much, just a bit too much. All at once you have to do everything, I think, yes, yes. (Respondent 13)	Facemasks are a bit of nonsense	Working with measures	
And euhm... you know normally you can just bring a bottle of water and per client I put it away and I can drink. And I just couldn't drink anymore. Euhm you were walking around with a headache, you were walking around with a thirst you had to keep that mask on until your next break. And at one point we had something like guys, but it also has to stay healthy we had a lot of headache complaints. (Respondent 1)	Headache and thirst because of wearing face masks		
In the morning care if you are going to shower or wash people, it is really hard stuffy. I myself have asthma, so you	It was stuffy with the facemasks when showering the residents		

notice that worse. Fortunately, I don't wear glasses, but many colleagues with glasses that covers every time, that is very annoying. (Respondent 10)			
I did look forward to putting it on not going in, absolutely not. But to wear the suit, yes. I found that horrifying. (Respondent 9)	Not looking forward to wearing the suit		
Difficult in the beginning because I have glasses and it covers every time, so I was completely a bit kiel. But at a giving moment you get useful there then do you think okay when I set him up, so it works. Yes. But yes and for the rest what is the name of it, of course to walk a lot outside so when I am outside, I did it down. Because and what's the name like what's the name when I had a break then we were allowed to take it off. (Respondent 9)	Tough work conditions with protection materials		
Euhm... it's mainly because you got all these other things in there, like normally people go downstairs for hot food in the afternoon with us, but at one point it wasn't allowed anymore, grand cafe closed. Everyone has to get the food upstairs, how are you going to do that? (Respondent 12)	Food delivery as extra task	Time pressure	
Yes, it's just less time for the residents. That just became yes ... in principle if you would do something extra with the resident, yes you did not at that time. You then outsource that for groceries, for example. Then you had family members who, for example, had put down messages. Then it had to be put in the	Hard because you do not have the time to visit the resident because of the extra tasks		

fridge and then it all took just a little too long according to the family of the resident and they just got angry there too. So yes there was all time pressure behind it. (Respondent 13)			
There was yes there was definitely less staff and sometimes, what's the name of that were they working, because we have to even if you were tested you had to work. Then one of them would come in and say yes, I have to go home, I'm positive, okay. Well, he would drop everything and then someone else would have to pick up, that's okay because we all do it together, it all works fine. (Respondent 9)	Less employees because of COVID infection		
Euhm... that nobody was allowed to come in from outside either. And that had a lot of negative consequences for the clients, but also for us. A lot of tasks were placed on the care team, where I normally only do the care request of a tenant, the AWL and medication dispensation. I was now also doing the dishes, emptying the garbage cans, changing the beds, and euhm... starting the whole procedure of how to do the laundry. (Respondent 1)	Lockdown causes extra jobs for the care staff workers		
Euhm... yes like yes yes... anyway in the first lockdown that was also that family was not allowed in. Then we had to do the shopping, laundry, everything. What the family normally did we had to take over. Because they were not allowed to enter the building. Sometimes the groceries were dropped off in the hall	Taking over the tasks of the residents family		

and we had to take them to the residents, for example. Or we had to bring something from the resident outside to the family members. (Respondent 13)			
Most common reason for workload is getting enough people on the work floor (ESS)	Most common reason for workload is getting enough people on the work floor		
I think the fear was definitely there with me namely. Despite the fact that you have personal protective measures. Well, there is always a chance of infection, only what we have been able to do is reduce it to a minimum, 100% is not achievable. And because you just work daily with people who are infected and also people who are not infected but still the family comes with and without complaints whether you know it yes or no. It certainly brought a risk with it. That also had a lot of impact and influence on private contact. (Respondent 3)	Afraid of infection others	Emotional exhaustion	
The second time yes euhm he had first just tested negative and two days later still positive, so we experienced both coronas together yes. (Respondent 2)	Infected her husband		
No actually I don't. No, I'm like you know the rules how to protect at work and what to wear. You know you have to throw it away afterwards, wash your hands well and disinfect. The only thing you see is that in terms of family, there are not many of them and at some point they don't all follow the rules anymore. At one point one person was allowed	Not afraid of getting infected		

inside and sometimes you see four people inside. In the beginning we really had a security guard walking around who euhm sometimes just looked in on people you know on the first floor they have a front door, so we don't have an overview of that. Sometimes the living rooms were full. (Respondent 12)			
If then the people who are still able to walk and then fall and suddenly die, you're like, shit, you know. He didn't have to fall and yes, that's eh... but at a certain point you're like, okay, it's the elderly. In the case of old people with underlying diseases, it quickly stops, as we have noticed. (Respondent 2)	Emotional exhaustion to see the residents depletion		
Pretty much, then I'll look for the right word, it did hurt to see. You understand of course that it's well you agree, some a little more than others. But you do it to prevent worse. That doesn't take away from the fact that a lot of people who already have little contact have even less contact. And groups that had already formed within the location over the years were no longer possible. So, the people were very much restricted in their social environment. (Respondent 2)	Painful to see the residents loneliness		
Well then I became very demotivated. Then I thought what am I actually doing it for. (Respondent 9)	Demotivated because family break the rules	Violation of the rules	
Not nice. Absolutely not because you don't want to hinder them in their things. Because it's already such a lonely yes .. Some what's the name of it one or twice a week to get someone over the floor and	Not nice to correct the family for not following the rules		

then no longer. So, then it will be yes life becomes lonely. (Respondent 9)			
At one point you feel more like a police officer than really paying attention. Is there family, is there not too much family, are they following the rules. So instead of being there for the residents themselves you're more playing police officer. (Respondent 9)	On a point feeling more a cop than care worker		
At one point we also had security guards at work from the family who did not come or only by appointment. Yes, they did not comply, and they went inside secretly and then you just work under security, which is not pleasant. (Respondent 12)	Security to correct the families		
How can we give the clients the best possible care, how can we bring a bit of conviviality, how can we make sure that euhm... yes can be together? (Respondent 1)	Delivering the right care	Quality of care	
Yes that is very frustrating that is absolutely very frustrating. Where you normally ensure that you have a conversation with the client while washing and dressing, now you can only do one thing. I have to get out of the door as soon as possible because there's still a lot waiting. So, um, that's not what you want because care workers want to care, and they don't want to rush things and I really felt that we short-changed the client in many ways. Because we just could not do otherwise. (Respondent 1)	Not being able to deliver the right care		

Second reason for workload is not enough time for the resident (ESS)	Second reason for workload is not enough time for the resident		
Yes we weren't even allowed to. I found that really frustrating. Because you really saw the people, some people just slip away because they wanted to do something with people, with their own group. What's the name of that at one point, yes, there was a bingo night but that was for certain people, for example. That was already six months late and I think you could have done something in those six months, could have arranged it. You see so many nice things being done at other Livio locations during the corona era and then with us nothing at all was allowed. And then we said something about it, and they said no, it can't happen because people can catch corona just like that and everyone had to protect themselves. Yes... sigh... (Respondent 9)	Frustrating to not be able to organise events for the residents	Decision authority	Job control
Absolutely no control over loneliness! (Respondent 9)	No control about the loneliness of residents		
Yes, yes we did have the opportunity to make our own decisions. (Respondent 9)	Able to make own decisions during COVID		
On the other hand, we didn't have a choice in that, and we kept discussing with each other also with the coordinators how are we going to shape this. This meant that we could put the garbage bags in the hallway so that someone would come and pick them up. So, we continuously consulted with each other, joined hands again, who is going	Dividing tasks continuously		

to do what tasks, how are we going to do it. (Respondent 1)			
So, for example, if you have the role or task of employee, then there are two employees in the team who ensure that if there is a vacancy, it is filled. For example, in the beginning when I came they did the job interviews themselves, but I felt that they lacked some quality. So, um... now we often do all the interviews um... together. And if there are still doubts, we then have a 'click' meeting with two employees to find out whether someone really fits into the team, so they do have some influence on who joins their team, for example. (Respondent 7)	Influence on the recruitment process		
Euhm... and they also needed me to tell them what was right, so euhm and now you notice that they are getting back into the position of making their own decisions and know that and euhm if I say something like 'well we're going to do it this way and that' they also sometimes say 'but can't we do better? So euhm... there is another, different flow at the moment. (Respondent 7)	More autonomy now COVID is fading away		
I think that when it comes to changing policy I think they should consult with me first. Then he is very something operational that fits within the policy. We use I don't know, call something simple euhm then I think that self care professionals know how to do it best, so you have to decide that yourself. When it comes to protocols, guidelines and	Policy changes needs to be discussed with C&C		

policies, for example the corona policy that is organization wide. Then I don't think they can make a decision on that themselves, without consulting me. (Respondent 14)			
No, no, no choice no, no. (Respondent 13)	There was no choice		

Appendix 4: Research Integrity Form

Research Integrity Form - Master thesis

Name: Nick Oosting	Student number: S1030878
RU e-mail address: Nick.oosting@student.ru.nl	Master specialisation: OD&D

Thesis title: How does COVID-19 infections of residents affect an organisational structure and thereby the quality of working life of care staff workers in high and low COVID-19 locations?
Brief description of the study: The thesis is a study in the field of nursing homes. The research is about the effect of COVID on the organisational structure and thereby the quality of working life of care workers in high and low COVID locations.

It is my responsibility to follow the university's code of academic integrity and any relevant academic or professional guidelines in the conduct of my study. This includes:

- providing original work or proper use of references;
- providing appropriate information to all involved in my study;
- requesting informed consent from participants;
- transparency in the way data is processed and represented;
- ensuring confidentiality in the storage and use of data;

If there is any significant change in the question, design or conduct over the course of the research, I will complete another Research Integrity Form.

Breaches of the code of conduct with respect to academic integrity (as described / referred to in the thesis handbook) should and will be forwarded to the examination board. Acting contrary to the code of conduct can result in declaring the thesis invalid

Student's Signature: **Date:** 02-06-2021

To be signed by supervisor

I have instructed the student about ethical issues related to their specific study. I hereby declare that I will challenge him / her on ethical aspects through their investigation and to act on any violations that I may encounter.

Supervisor's Signature: ______________________ **Date:**