



# Overcoming COVID-19 Constraints on Person Centered Dementia Care: A Narrative Inquiry of Lived Experiences of Residential Care Staff in Belgium

RESEARCH

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## ABSTRACT

**Context:** Person-centredness is integral to high-quality dementia care. The coronavirus prevention and control measures significantly disrupted delivery of person-centred dementia care.

**Objective:** To explore the lived experiences of residential care staff of overcoming the coronavirus constraints on person-centred dementia care.

**Methods:** A narrative correspondence inquiry undertaken between August and October 2020 engaged three ( $n = 3$ ) residential care staff in Belgium. Criterion sampling included staff involved in caring for people with dementia in an organisation providing a multitude of residential care services.

**Findings:** Four overarching themes were identified, comprising the chaos embedded in uncertainties, restructuring the service, transition shock, and reorienting the service to person-centred care. Working with unfamiliar procedures disorganised the care environment and the ability for residents to take part in meaningful activities. Residential care staff creatively remodelled person-centredness around the coronavirus prevention and control measures to restore continuity of good standards of dementia care.

**Limitations:** The correspondence method of gathering narratives was opportune for undertaking qualitative research during the peak of the coronavirus pandemic and provided a means of exploring in-depth the experiences of staff. However, this study is limited to a small sample of participants from one organisation.

**Implications:** The coronavirus pandemic not only introduced challenges but also prospects of effective ways of delivering care to adequately meet the needs of people with dementia. The hierarchical boundaries several disciplines often create in health and social care defy effective collaborations in dementia care.

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## INTRODUCTION

The coronavirus disease (COVID-19) outbreak disorganised global systems of health and social (long-term) care to the detriment of person-centeredness, an integral practice in high-quality dementia care. Dementia is a collective term used to describe the range of conditions characterised by progressive deterioration in cognitive function (World Health Organisation, 2021). Person-centeredness in dementia care entails mutually respecting and trusting relationships that enable the broader understanding of the uniqueness of individuals, their preferences, and needs (Fazio et al., 2018). This requires understanding the person's views of the physical and social environments to enable them to maintain confidence and self-esteem (Surr et al., 2016). Reactions to COVID-19 in the West assumed a shared approach of focusing more intensely on acute care in hospitals and less on events in community care settings (Krones, Meyer and Monteverde, 2020). Caught up in the crisis of treating and preventing further COVID-19 casualties, little or no consideration was given to perspectives of people in long-term care with impaired cognitive function. Converting memory clinics into critical care spaces, relocating healthcare professionals outside of specialist practice, suspending much routine monitoring of people receiving care and support, and suspending socialising centres all disintegrated person-centred dementia care pathways (Canevelli, Bruno and Cesari, 2020; Parker et al., 2020). Indications of unmet need, such as anxiety and agitation, among people with dementia increased due to disrupted routines and substantial changes in the care environment (Simonetti et al., 2020).

Residential care homes were faced with unfamiliar processes of preventing and controlling the COVID-19 infection spread in closed environments without the essential equipment (Gillain, Belche and Moreau, 2020). The COVID-19 situation in residential care homes in Belgium turned into a humanitarian crisis wherein 64% of the country's total number of COVID-19 deaths occurred within six months of the COVID-19 global outbreak (Médecins Sans Frontières [MSF], 2020). Measures applied with an emphasis on safety contravened the core values of person-centeredness in dementia care (Ho et al., 2021). For example, dividing up spaces to separate infected from non-infected cohorts in care homes suddenly located people with dementia in unfamiliar spaces in the absence of a familiar face (Brown et al., 2020). To calm the anxiety and agitation among people with dementia whilst the supply of regular medication was interrupted, the use of antipsychotics without adequate monitoring intensified (Brown et al., 2020; Canevelli, Bruno and Cesari, 2020; Velayudhan, Aarsland, and Ballard, 2020). Personal protective equipment (PPE) masked nonverbal cues that are essential for interpersonal reassurances

in dementia care (Parker et al., 2020). The current study aimed to explore the lived experiences of residential care staff of overcoming the COVID-19 constraints on person-centred dementia care.

## METHODS

### STUDY DESIGN

A narrative correspondence inquiry (Grinyer, 2004), which is rooted in phenomenological research, was used to study the lived experiences of overcoming the COVID-19 constraints on person-centred dementia care. A narrative inquiry gathers stories of lived experiences as told by individuals (Creswell and Poth, 2016). In phenomenological research, individuals tell of their lived experiences of being with others in a social context (Frechette et al., 2020). The correspondence method empowered study participants with control of the research process to document stories without the researcher's presence (Milligan, 2005). I presupposed that residential care staff actively accumulated knowledge of overcoming the COVID-19 constraints on person-centred care through caring for people with dementia during the pandemic. On the other hand, I interpreted the meaning of participants' narratives to integrate multiple subjective realities to understand the collective phenomenon (Rashid et al., 2019). The overall design of the study allowed for expressing narratives of difficult experiences in my absence. The presence of a researcher during in-depth interviews may place unnecessary pressure on participants due to expectations of immediate responses (Milligan, 2005). I used the consolidated criteria for reporting qualitative research [COREQ] (Tong, Sainsbury, and Craig, 2007) to improve the openness of documenting the study procedures. The COREQ is an all-inclusive checklist for reporting key elements of a qualitative study design and about the research team.

### STUDY CONTEXT AND PARTICIPANTS

The study occurred in a residential care setting of a not-for-profit organisation in Flanders, Belgium. Long-term care in Belgium is financed through compulsory health care insurance (57%), general direct taxation (37%), and co-payments (6%) (Organisation for Economic Co-operation and Development, 2011). The not-for-profit organisation included other service departments for long-term residential care, with more than 100 beds for people living with dementia. Nonetheless, criterion sampling (Palinkas et al., 2015) sought to include staff working in the residential dementia care unit. I sent the electronic flyer calling for narratives, the information sheet, and consent form, via email, to the team leader of the dementia care unit to distribute to the rest of the team. I included my contact details on the documents dispatched through the team leader for potential

participants to send their consent to take part in the study and/or obtain more information about the study. I knew the team leader through a collaborative initiative for improvements in dementia care. However, I did not know the participants before the study. Volunteering participants emailed me their endorsed consent forms before obtaining narrative prompts to guide the process of documenting their experiences. Three ( $n = 3$ ) out of potentially eight participants working in the dementia care unit responded to the call for narratives. Participants comprised an occupational therapist, a care coordinator, and one physiotherapist. All participants had received training in the pillars of person-centred dementia care (Kitwood, 1997) before the COVID-19 pandemic.

### ETHICAL CONSIDERATIONS

The study obtained clearance from the ethics governance board of the participating residential care unit and the faculty ethics committee ref: ETH1920-0299. Grounded on my substantial experience in collecting primary qualitative data, I asked participants for permission to use anonymised quotes from their narratives. The participant information sheet included information signposting existent organisational support for any potential distress arising from the study or their work.

### DATA COLLECTION

I used the email correspondence approach to collect narratives from the study participants (Grinyer, 2004). Participants used narrative prompts to document their experiences in their own time (Grinyer, 2004; Milligan, 2005). I piloted the narrative prompts with staff in a residential care setting in the United Kingdom. Narrative prompts comprised two guiding prompts and an invitation for participants to document anything else they wished to mention about their roles during the pandemic. The core questions were:

- What has been your experience of providing person-centred dementia care during the COVID-19 pandemic?
- What changes in person-centred dementia care have you observed over time?

I gave participants the option to either audio record or type their accounts between August and October 2020. The email correspondence method offered an open platform for me to contact individual participants again to fill in information gaps identified in the narratives. For example, I contacted participants to inquire about how often they documented their experiences. All participants audio recorded their narratives in one day and emailed me their encrypted files. I contacted participants individually to gain access to the security-protected files for transcription. Participants' narratives were

comprehensive without significant variation in depth, totalling about 3,200 words altogether.

### ANALYSIS OF NARRATIVES

I transcribed the narratives verbatim and sent the encrypted transcripts back to individual participants to validate the content. I used paradigmatic reasoning (Kim, 2016) to analyse the content of narratives and to align the findings with the purpose of the study. The paradigmatic rationale was useful for generating codes and categories to develop conceptual presentations of the narrative data. I first read participants' narratives to obtain holistic insights into their meaning. I distinguished residential care staff's transition through navigating the COVID-19 information limitations and the changes in the service in response to the COVID-19 guidance in Belgium. I designated the transition process as the unit of analysis for experiences in the residential dementia care context. Drawing on Anderson, Goodman, and Schlossberg (2012)'s stages of a transition, I read the narratives several times to familiarise myself with the narrative data and consequently develop short phrases describing commonly mentioned experiences. Anderson, Goodman, and Schlossberg (2012) stipulate that a transition constitutes three phases including moving in, moving through, and moving out. While moving in signified entry into new COVID-19 circumstances, moving through involved working with the demands of the new situation, and moving out connoted a period of relative stability. Transition theory (Chick and Meleis, 1986) also presupposes connecting experiences of events integrating both process and outcomes of a multitude of contextual interactions. I therefore interpreted the lived experiences of residential care staff in the context of their interactions with others mentioned in the narratives (Wang and Geale, 2015) as they forged continuity in a disrupted dementia care setting. I retained the language participants used in their narratives as much as possible to describe common experiences. Narrative data saturation was reached if the story as told by individual participants was whole without information gaps (Saunders et al., 2018). Figure 1 presents the analysis grid of codes, patterns, and themes generated from the narrative data. I developed deductive themes through comparing the short descriptions of experiences across transition phases and questioning of residential care staff's purposeful activity towards person-centred dementia care. I emailed the analysis grid to participants along with the short descriptions of the deductive themes to crosscheck whether the results were representative of the experiences expressed in their narratives. Participants individually agreed that the analysis and short descriptions of themes were reflective of their lived experiences of working through the COVID-19 constraints on person-centred dementia care.

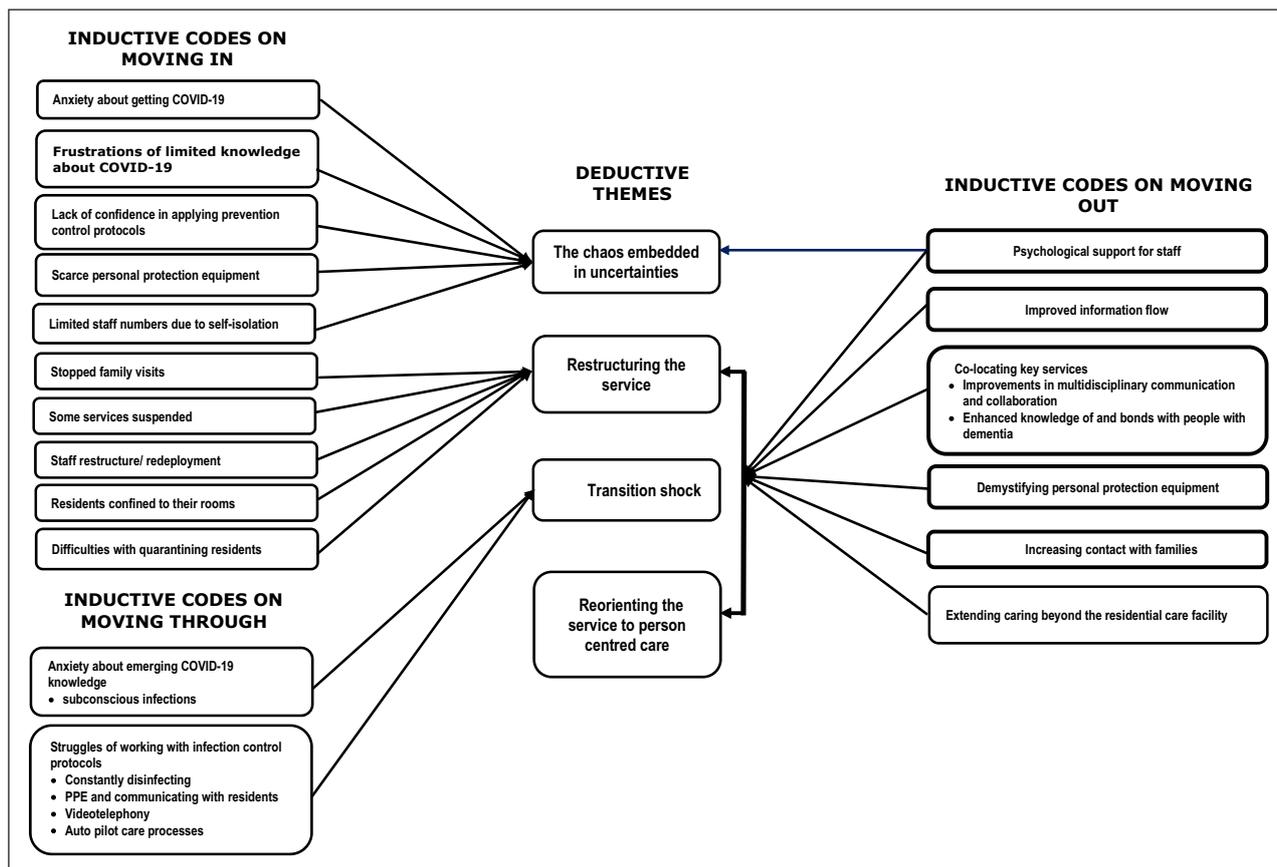


Figure 1 Analysis grid of codes, patterns and themes from the narrative data.

## FINDINGS

I identified four themes encompassing residential care staff’s transition from the disrupted care environment to establishing some form of stability during the COVID-19 pandemic. The themes include: 1) the chaos embedded in uncertainties; 2) restructuring the service; 3) transition shock; and 4) reorienting the service to person-centred care. The overlap in the themes presented in the findings is reflected in the participants’ accounts. For example, some experiences of moving out of circumstances disrupting the care environment dovetailed restructuring the service.

### 1. THE CHAOS EMBEDDED IN UNCERTAINTIES

The COVID onset generated several anxieties surrounding the unknown and perceivably new workload pressures for residential dementia care. Participants reported a cloud of uneasiness due to the accurate information about the manifestation of COVID-19, requirements for self-isolation, and the potential impact of the outbreak on the care environment for people with dementia. Safety became the focus and concern during personal care processes. A general lack of confidence to apply safety protocols correctly and anxiety about the economic use of scarce personal protective equipment (PPE) existed. Participants echoed:

In the beginning, everything involved a bit of exploring and it was unclear how everything

moved, from the department to the materials and who should be self-isolating. There were a lot of questions... [Care Coordinator].

What I felt extra pressured about was the lack of information—no one could tell you how long the COVID-19 situation would last, no one could say what was coming or how to best deal with it. It was new to everyone... No one was trained to apply the measures correctly from day one in such a situation, and we also had to deal with the scarcity of the protective materials [Occupational Therapist].

Participants suggested that staff at the frontline of dementia care looked up to management for support to implement the COVID-19 related changes effectively and for optimum information flow about keeping safe. Conversely, managers of the residential care facility carried anxieties comparable to the fears of frontline staff. Participants linked the COVID-19 onset to absolute chaos that prevailed both at work and in private lives as the participants reflected:

Every working hour was just an uncertainty. Was the coronavirus already with us, and what impact would this have on our residents and our colleagues? We were uncertain as to what measures to follow and uncertain as to whether

we applied them well, uncertain about what to do as a job on the day, uncertain about the availability of protective equipment and you name it! Every bike ride to work involved worrying about what chaos you would find and what will have changed [Physiotherapist].

As a coordinator in a leadership position, I also had a small fear of becoming infected, taking the infection home and specially to continue infecting the residents [Care Coordinator].

## 2. RESTRUCTURING THE SERVICE

Residential dementia care was rapidly restructured to mirror the national COVID-19 prevention and infection control guidance in Belgium. In the beginning, residents were confined to their rooms. Participants reported that it was quickly realised that quarantining people living with dementia was not feasible unless drastic measures such as the use of antipsychotic drugs were applied. The residents' freedom of movement was reinstated as other methods to keep residents safe from COVID-19 were pondered. Participants stated:

It is difficult to keep residents with dementia in isolation. There is often use of antipsychotics and restraining methods but that is completely against our way of delivering dementia care...Residents kept going to the common living room... We tried to encourage people with some mental capacity to wear face coverings, but after a while they took them off anyway, so that was not really an option [Care Coordinator].

It was decided that general quarantine in our unit is not really feasible and residents were therefore allowed to stay in the living room instead of all staying in their rooms [Physiotherapist].

Redeploying staff to areas of high service demand followed a pause on some routine services like physiotherapy, where physical contact was necessary. Participants suggested that the reorganisation brought staff closer, forming reciprocally supportive teams. Assigning all staff to hands-on personal care created opportunities for more prompt responses to dementia care needs than the usual tiered role-based setting. Participants reported improved cooperation and care coordination in newly formed teams because communication was smoother and more direct than usual. Residential care staff were also able to use specialist skills for services that had been suspended, such as physiotherapy to maintain the wellbeing of people with dementia. Residents benefited from a much more familiar and quieter space than the usual treatment rooms often used by the various units in the organisation. Participants reiterated:

I was able to set up a space as a physiotherapy room and I quickly noticed that this brought a lot of benefits to me and my residents. I started with an exercise bike, but since we now know that the situation will not change anytime soon, I and my colleague have made ergotherapy, though I say it myself, something fun! As a kiné [physiotherapist] I feel much more connected to the other disciplines...I also hear a lot of positive reactions from other staff that they are surprised what I residents can do! I feel that the space for them is much more familiar and quieter than the space where all departments come together for therapy.

We also experienced a lot of extra calmness with certain residents. There were fewer stimulants, which is beneficial for some residents [Occupational Therapist].

Participants reported that staff who usually worked in day care were deployed in the living room to support videotelephony between residents and their families to reduce the impact of restricted family visits on the residents. Participants suggested the service restructure brought staff close to the people living with dementia and they felt more confident to nurture the residents' abilities than in the usual care setting where some capabilities were unrecognised. Participants echoed:

It is also positive that we have [a multidisciplinary team] in the department during this period. It used to be a separate space for therapy but here the team can see a lot more about what residents do there and they are amazed by what residents are still capable of [Care Coordinator].

During the first months of the coronavirus, there were different disciplines that helped during the morning care.... This brought the staff closer together and even closer to the residents themselves [Occupational Therapist].

## 3. TRANSITION SHOCK

Transition shock identified residential care staff's states of role confusion and a lack of confidence when working with unfamiliar procedures against the evolving knowledge about COVID-19. The sub-themes, subconscious infections, and working with the COVID-19 protocols encapsulate the interactional challenges that contributed to residential care staff experiences of the transition shock.

### 3.1. Subconscious infections

Knowledge about COVID-19 and its manifestation evolved and anxieties surrounding asymptomatic cross infections further destabilised the care environment. Participants relayed worries of transmitting COVID-19

among themselves and the residents whom they deemed vulnerable. Participants stated:

I had the fear and still have of infecting our residents without knowing it. The virus can be transmitted even if you do not experience any symptoms yourself. For me, the subconscious passing it on is a greater fear than getting the virus [Occupational Therapist].

...the fear of infecting residents will always be there. [Name] wasn't afraid of getting sick himself, but he was very afraid of actually making colleagues sick and certainly our residents, because they are in the at-risk group [Care Coordinator].

### 3.2. Working with the COVID-19 protocols

COVID-19 prevention and control protocols presented predicaments for person-centredness in dementia care. Participants described taking extra caution in all situations to prevent cross infections, more so where residents showed symptoms of COVID-19. Participants suggested the care environment changed from a community to a clinical feel during the first months of the pandemic when staff focused on applying COVID-19 control measures correctly. The sudden change made some residential care staff feel like they had a pathological fear of germs and contamination. One of the participants expressed:

...I found it especially difficult to disinfect hands and devices after each contact. It just makes me feel like residents made me dirty, or something like that. I wash my hands regularly anyway, but the fact that I must disinfect between contacts invariably makes it all a bit more clinical and less humane for me. Having to wash hands my because I have held a resident's hand to comfort them remains absurd to me [Physiotherapist].

The access to PPE improved in the later months of the COVID-19 pandemic and the rigour in its continued use ensued. Participants reported that the opaque mouth coverings were a barrier to smooth communication, particularly with the people who were hard of hearing. Showing emotions through a face mask and using the vital nonverbal cues to connect with people with dementia were challenging as participants expressed:

People with dementia need clear expression, proximity, and a sense of safety but we cannot often offer these important pillars during this period...The masks hide our smiles. I have had a difficult time in situations where the resident gets agitated. You do your utmost to find a creative solution so that you can still offer that sense of security [Occupational Therapist].

And gosh, that mouth mask and all that the protective material. It makes us struggle with communication, especially with people who are hard of hearing. Communication is difficult [Care Coordinator].

Videotelephony used to maintain contact with residents' families elicited mixed reactions. Some residents were happy and looked forward to the conversations with their loved ones. However, videotelephony engendered negative emotions for some residents, who found the sudden disappearance of the person on a screen challenging. Negative emotional reactions were also witnessed among family caregivers, particularly those who were actively involved in the lives of their loved ones before the COVID-19 outbreak. Participants reported staff resorted to recording video messages for residents distressed by videotelephony, which were played at suitable times. The care coordinator stated:

There are also positive things like the day care team were deployed in the living room for extra animation and video conversations and so the residents did not really feel that they were less visited... The video calls were sometimes good but not so good with other people because they were very emotional about it...

Palliative care was an area of contention that residential care staff grappled with. Following the prolonged loneliness of the person with dementia in an isolated room during the illness, families were not permitted sufficient time with the person during the last hours of life. One of the participants conveyed:

The palliative situation is very difficult. We have had some in this COVID-19 period and the families were only allowed a quarter of an hour. I found that upsetting. They were allowed to watch the dying person, but they were not allowed to touch. In one situation the doctor pointed out that they should not touch, even though the person's COVID-19 test was negative. That was hard for me to watch [Care Coordinator].

## 4. REORIENTING THE SERVICE TO PERSON-CENTRED CARE

Changes in residential dementia care in response to COVID-19 implied that staff and residents were faced with unusual circumstances, requiring adjustments for each one of them to find a balance within the new practices. Participants reported good communication flow, especially regular updates on using PPE safely, established a sense of calmness among staff. Participants echoed that the organisation offered residential care staff ongoing psychological support to enhance wellbeing and

effectiveness in the workplace. However, participants recounted a shift in responsibility and accountability to support the wellbeing of people with dementia. The logic of social distancing in public spaces such as supermarkets or when visiting relatives after close contact with residents at work was easy to falter. Nevertheless, the responsibility of protecting residents automatically extended from the work environment to staff's social lives as participants expressed:

I also notice that because of my job I have to be careful when I return to the outside world...you have had close human contact since 8am and then you have to keep 1.5 metres away during shopping or when you visit your parents. This does not make sense at all [Physiotherapist].

I am always very careful in my private life, knowing what I do and whom I see. I have a responsibility at work and automatically take this with me to a private situation. I feel responsible for the residents' safety [Occupational Therapist].

Putting the person living with dementia at the centre of care delivery had become secondary to COVID-19 infection prevention and control measures. Participants reported that during the later months of the pandemic, staff realised the necessity to refocus their attention to the key aspects of dementia care. The practicalities of person-centred practice had to be weighed against positive risk taking. Reflecting on this point one participant said:

Everyone has had to wake up a colleague about not losing our focus on what matters. There was a sudden shift in focus on the virus, especially in the first few months. We are trying to restore our focus to providing good person-centred care to our residents, but within COVID-19 measures as an extra point of attention. In dementia care proximity, touch and a sense of security are very important. I have had to reflect on moments where distress would normally disappear mainly through a hug, a smile, and or a chat. I must consider carefully what I can and will do [Occupational Therapist].

Participants suggested residential care staff made PPE playfully fun, keeping within the remit of clarifying an outbreak of a dangerous virus from which they needed to protect residents. Most residents were receptive to the comedy, branding PPE the new fashion or clean sleeping clothes. Other efforts to demystify PPE that were reported involved using art to illustrate the need for maintaining safe distances and role-play to empathetically convey an awareness of the challenges of communicating effectively through the opaque layers of PPE. Participants iterated:

Communication is difficult. In the meantime, residents are used to the appearance of face masks and the full protective gear—the apron and gloves, because I am playful with it. I go along with the residents' perceptions of me, for example making sure that I look like I come from another planet. I am usually well received by the residents...[laughter]...just by being playful... [Care Coordinator].

Of course, we also experience funny reactions from residents who were not aware of the virus. I try to be as playful as possible with all the protective equipment some residents also go along with it. An example of this is a resident who calls our protective clothing 'the new fashion' or 'clean sleeping clothes' [Occupational Therapist].

Learning about COVID-19 on the job may have been an overwhelming task but also an opportunity to rediscover the benefits of multidisciplinary teams and challenge established practices that required improvement. Participants expressed that managing palliative care during the COVID-19 pandemic provided deeper insights into requirements for improvements in dementia care beyond the pandemic. Designating a room for palliative care with strict entry restrictions in the care environment did not denote person-centeredness at end of life. Participants positively reflected on lessons learned and areas for improvement particularly around involving families in the care of the people with dementia.

## DISCUSSION

Restrictions aimed at preventing multiple transmissions of COVID-19 disintegrated partnerships in planning and delivering person-centred dementia care. Person-centeredness, which is the cornerstone for good standards of dementia care, was broadly tested within new processes of delivering care. The COVID-19 national responses constricted the decision-making capabilities of residential care facilities, and staff had to work creatively to restore good practice (Krones, Meyer and Monteverde, 2020). Anderson, Goodman, and Schlossberg's (2012) transition theory was a useful conceptual framework for discerning the changes in person-centred practice study participants recounted. Chaos epitomised moving into the extraordinary circumstances while transition shock distinguished the moving through phase. The lived experiences of residential care staff of restructuring the service overlapped with experiences of reorienting the service to person-centred care. Restoring person-centeredness in dementia care marked the beginning of moving out of situations disrupting the care environment to re-establish relative stability and good dementia care practice.

Disruptions in the long-term care environment may stimulate indications of unmet need, such as aggression, anxiety, and wandering among people with dementia (Chaudhury et al., 2018). The sudden changes in the physical and social environment of people with dementia occurred in addition to the imprecise and constantly changing COVID-19 guidance (Bunn et al., 2021). The catastrophes recorded in care homes in Belgium (MSF, 2020) are reflected in the challenges of moving into the unusual situations that study participants characterised as absolute chaos. Prioritising hospitals for optimum information flow and personal protective equipment disproportionately affected care homes (Gillain, Belche, and Moreau, 2020). Positive transitions are featured in mutual processes and outcomes (Chick and Meleis, 1986). Transition shock, on the other hand, entails a state of disorientation usually experienced by newly practicing healthcare professionals (Duchscher, 2009). Unfamiliar COVID-19 infection control measures engendered a lack of role clarity and constant doubt in residential dementia care. However, active organisational and peer support systems constituted core processes for residential care staff to work through disruptive situations and remodel person-centred dementia care during the COVID-19 pandemic. The multidisciplinary residential care teams forged effective partnerships through eliminating the red tape and communication hierarchies usually involved in cross-disciplinary working. Co-locating multiple specialisms is an encouraging result for enhanced collaboration and wider prospects of providing technical aspects of dementia care. Findings of the current study offer insights into opportunities for restructuring the usual residential dementia care settings to stimulate active better multidisciplinary partnerships and person-centred relationships within teams.

Continuity in person-centred dementia care requires a shift in culture supported through leadership and shared responsibility within teams (Borbasi et al., 2011). Study participants did not attribute reorienting the service to prior training in person dementia care. However, it is plausible that the knowledge of staff of person-centredness in dementia care formed a strong basis for persisting to reinvent ways of working alongside the COVID-19 pandemic. Beer, Hutchinson, and Skala-Cordes (2012) posit that awareness of person-centeredness in dementia care challenges the workforce to constantly reflect on service delivery styles and their impact on the people with dementia. This is mirrored in the efforts of residential care staff to adapt the care environment, drawing on logic and problem-solving capabilities to remodel person centredness to meet the needs of people with dementia. This exploratory observation merits a focused evaluation of the effectiveness of person-centred dementia care in an environment deranged by unexpected circumstances, such as COVID-19, to generate conclusive evidence of how it works.

## LIMITATIONS OF THE STUDY

The electronic correspondence method enabled participants to record detailed accounts of their experiences within a safe mental space. The narrative correspondence inquiry is a counterpoise to the dominant researcher-researched power relations often conceived in the researcher's presence. The study, however, constituted a small sample (n = 3) from one organisation providing residential dementia care. While a small sample is not usually a concern for in-depth narratives (Schoch, 2019), the findings do not include the lived experiences of other residential care staff such as care assistants. Organisational hierarchies often turn into a political field where staff at the top set the agenda. On the other hand, people may perceive researchers' assumptions of the plausible enthusiasm of others to take part in research as an additional task to an already overwhelming workload (Lebesby and Benders, 2020). The correspondence method offered neither the opportunity to maximise the participation of residential care staff nor the possibility to establish why some staff were inclined not to participate in the study.

## CONCLUSION

The unpredictable trends of the COVID-19 pandemic and related guidance for individual and social circumstances compromised the standards of residential dementia care. However, the pandemic not only introduced challenges at the onset but also prospects of more effective ways of working than normative structures to meet the needs of people living with dementia adequately. The study identifies the significance of flexible teams, leadership support, maximising communication flow, collaboration, and working with a shared vision a smooth transition when restructuring services. Moreover, familiar environments crucially complement the structure, safety, and security in dementia care (Førsund et al., 2018). The awareness of the benefits of person-centeredness in dementia care possibly empowered residential care staff to creatively remodel care processes and social interactions to optimise the wellbeing of people with dementia. Close multidisciplinary working conceivably dissolved the hierarchical boundaries several disciplines often create in health and social care. While practice values underpin ethical choices, person-centredness is synonymous with ethical dementia care (Cousins and Vries, 2021). Embedding person-centredness in care within provider organisational values could support the continuity of good standards of care during social crises such as the COVID-19 pandemic.

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## COMPETING INTERESTS

The author has no competing interests to declare.

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