Sensemaking in a pandemic: how the environment of nursing homes framed their response to Covid-19

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SENSEMAKING IN A PANDEMIC: HOW THE ENVIRONMENT OF NURSING HOMES FRAMED THEIR RESPONSE TO COVID-19

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GLOSSARY AND ABBREVIATIONS

AGEMS : Association Genevois d'EMS
Conseil d'Etat: State Council - Executive authority of Geneva canton
Conseil Fédéral: Executive authority of the Swiss Federation
CURAVIVA / Artiset : Federal association of EMS,
DGS: Direction Générale de la Santé - General Health authority for the canton
EMS: Etablissements médico-sociaux – Medical social institution – nursing homes in Switzerland
EMS Covid Task Force: Task Force set up by EMS in Geneva during the Covid-19 pandemic
FEGEMS: Féderation Genevois d'EMS
Grand Conseil: Grand Council - the legislative authority of the Geneva canton
GRESI: Groupe risque pour l'état de santé et inspectorat – Geneva Canton health inspectors
HUG: Hôpitaux Universitaires de Genève - University hospitals of Geneva
IMAD: Insitution Genevois de maintien à domicile - Geneva institute of home care services
OFS : Office federal de la statistique - Federal office of statistics
OFSP: Office fédéral de la santé publique - Federal office for public health
PLAISIR: Planification Informatisée des Soins Infirmiers Requis - digitalized planning of required nursing
SMC: Service du Médecin Cantonal - the state medical authority of Geneva canton

ACKNOWLEDGEMENTS

Last year I carried out a first study in a nursing home as part of my master's programme, aiming to understand the experience of staff and residents in the first year of the pandemic. This master's thesis picks up where the last study concluded. I wanted to take a step outside the nursing home to see in what way the broader institutional environment impacted the response to the pandemic.

Carrying out a study on such an extreme situation, gives one a privileged insight into the difficulties, achievements, and contradictions of providing institutional care to an elderly frail population.

I could not have done this without the generosity of those who shared their experiences, who took the time to explain to an outsider. I am extremely grateful to all the EMS members who accepted to be interviewed, as much for this study as the one I did before which allowed me to catch a glimpse of what the nursing homes have tackled. This would not have been possible without your time and openness.

I wanted to also thank the people I interviewed from the health authorities, association members, the geriatric ward of the HUG and the staffing agencies, who all took the time to explain the issues they grappled with in the pandemic.

Mathilde Bourrier, my supervisor, thank you for encouraging me to take this challenge and for your unwavering support and guidance.

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INTRODUCTION: NURSING HOMES ON THE FRONTLINE OF THE PANDEMIC

Nursing homes for elderly people found themselves on the frontline of the Covid-19 pandemic. Whichever the country, health system, or pandemic response, whenever there were nursing homes for the elderly in a country, then those living there would likely bear the brunt of the pandemic.

Elderly people are vulnerable to developing a severe form of Covid-19 and collective settings represent a high-risk area for contagion, particularly when people require close physical contact for care. Data from 20 countries[1] collected through the International Long Term Policy Network, show that death of nursing home residents account for anywhere between 20% to 70% of all Covid-19 deaths depending on the country (Comas-Herrera, Marczak, et al., 2022).

Research in different countries on the impact of Covid-19 in nursing homes identify similar types of problems. Mainly a failure to prioritize nursing homes within the national response leading to a variety of delays specially at the beginning of the pandemic. Such as delays for nursing homes to access personal protective equipment (PPE) and tests , delays in implementing infection control measures and in increasing the home's capacity for care delivery, and delays to support and increase staff capacity (Inzitari, Risco, et al., 2020).

COVID-19 IMPACT ON NURSING HOMES IN SWITZERLAND

In Switzerland the responsibility for long-term care facilities is organised at cantonal level. There is a variety of different policies within the country, leading to large differences between nursing homes, but overall Switzerland is one of the top five OECD countries in terms of highest investments and staff ratios in long-term care facilities (OECD, 2020, 2022).

Nursing homes in Switzerland are referred to in French as an 'Etablissement Medico-Social' (Medical Social Institutions) or EMS for short. The name brings together the idea that both medical care and social interactions are important parts of care. Over the past decades nursing homes have placed increasing emphasis on the individuality, dignity, and freedom of choice of residents where relationships inside and outside the institution are an integral part of care (Freidus, Shenk, et al., 2022). However, the arrival of Covid-19 disrupted the habits and relationships of residents and placed emphasis on infection control measures and outbreak management.

Nursing homes across the country were impacted. The pandemic led to a 16% increase in the number of deaths in EMS across Switzerland in 2020. This represented an extra 5600

[1] Australia, Austria, Belgium, Canada, Denmark, England (UK), France, Germany, Hungary, Ireland, Netherlands, Northern Ireland (UK) , Portugal, Scotland (UK) Slovenia, Spain, Sweden, Switzerland, USA and Wales (UK).

more deaths in EMS compared to those in 2019 and 2018 (OFS, 2021, p. 10). Most of the excess mortality was in the second wave of the pandemic when an extra 4600 deaths occurred compared to the same period in 2018 and 2019 (OFS, 2021). Of these extra deaths, 77% (3532) were reportedly due to Covid-19 (OFSP, 2021) with no reported reasons for the other 23% (1068) extra deaths. They could be unconfirmed Covid-19 deaths, or a result of other indirect causes such as a weakened immune system or due to lockdown and isolation. In Geneva canton, EMS resident deaths represented 73% (532 out of 720) of all Covid-19 deaths from September 2020 up until March 2021, most of them also occurred in the second wave (SMC, 2021). It bears noting that in the years prior to the pandemic an average of 43.7% of all deaths in Switzerland happened in nursing homes (OFS, 2021), showing the prominent role of EMS in providing end of life care to a large proportion of the population in the country.

The pandemic also impacted the mental health of residents and staff and challenged a person-centred approach to care in nursing homes (Freidus, Shenk, et al., 2022). Isolation and lack of contact with families led to emotional suffering, and a failure to thrive for residents. In May 2020, during the first wave of the pandemic, a Federal Task Force charged with providing ethical, social and legal advice to public authorities during the pandemic, published a briefing paper on the confinement of vulnerable people (Swiss National Covid-19 Science Task Force, 2020). In it they called for the lifting of bans which impeded families from visiting relatives living in long-term care facilities. They also called for the adherence to existing standards of care which included respecting the social needs and quality of life of residents.

There is no data to assess to what extent protection and isolation measures accelerated loss of autonomy and cognitive difficulties, and even death, but it was clearly not an isolated event. Descriptions of the emotional toll of isolation appear in different studies carried out in Switzerland including national surveys commissioned by the federal health authorities (Fries, Trageser, et al., 2021; Trageser, Weber, et al., 2021; von Stokar, Vettori, et al., 2021; Huber and Seifert, 2022).

EXPERIENCE FROM A NURSING HOME: RESULTS FROM A CASE STUDY IN GENEVA

In 2021 as part of my sociology master's research workshop, I set out to document the experience of residents and staff in a nursing home, to better understand how the pandemic impacted their lives and the nursing home's capacity to provide care. The study focused on the experience of a nursing home in Geneva during the first two waves of the pandemic before vaccinations were rolled out (de Rivero, 2022). Based on interviews with 19 staff members and 6 residents, the findings revealed two modes in which the pandemic impacted the nursing home's ability to deliver care.

In the first mode, there was no Covid-19 outbreak inside the nursing home, and the staff focused on reconciling two priorities: implementing protective measures to shield residents from the virus whilst at the same time trying to safeguard the residents' quality of life. In the second mode of impact, an outbreak of Covid-19 spiralled into a full-blown crisis as infection rapidly spread throughout the nursing home. Over the course of a few weeks, 70 out of 98 residents were infected, 22 died, and over half the staff was infected. This was depicted as a traumatic experience by all interviewed. Staff describe the outbreak like a tsunami of infection and deaths, that swept away their ability to provide proper care.

This study was inward looking and focused on what happened inside the nursing home, but little was said on how the EMS fit into a larger pandemic response strategy or how interactions with actors in its environment affected the response. Yet in Geneva about 30% of EMS were impacted with outbreaks in the first wave , while 75% were impacted in the second wave (SMC, 2021). I was curious to understand if there were any broader systemic issues to be identified in the sector, that influenced the EMS response and their capacity to deliver care.

SITUATING NURSING HOMES WITHIN THEIR ENVIRONMENT, A LITERATURE REVIEW

Three types of themes can be found in studies on the nursing home institutional environment and the pandemic outcomes: one type tends to look at the underlying systemic or structural factors which impacted the pandemic response, another looks at the experience of emerging organisations that arose to support nursing homes, and a third looks at areas of interdependencies between nursing homes and external organizations.

PRE-PANDEMIC FACTORS INFLUENCING THE RESPONSE

Several European and North American studies underline how pre-pandemic systems framed the response to the pandemic in nursing homes (such as Daly, 2020; Estabrooks, Straus, et al., 2020; León, Arlotti, et al., 2021; McGarry and Grabowski, 2021; OECD, 2021; Daly, León, et al., 2022). They tend to show two main things: first, the more nursing homes were embedded in the public health system or were prominent in policies on the provision of long-term care, then the more likely they would have been rapidly considered in the pandemic response; and secondly, the less there was an integrated approach to care – such as a hard separation between social and health systems, or between primary and secondary care - then the more hospitals tended to be prioritized at the expense of nursing homes.

One study compared the response in five countries – Denmark, Germany, Spain, Italy and England - looking at the time it took for nursing homes to be included in national pandemic response actions. The study found that all five countries prioritized hospitals over nursing homes, but to different degrees. Denmark and Germany were much quicker to develop a proactive approach that included nursing homes, whilst the others were much more delayed. Both Denmark and Germany prior to the pandemic had a much higher investment and regulation of nursing homes, and a centralized coordination of nursing homes in terms of integration into long-term care policies. Spain, Italy and England, had low investments and little regulation of the nursing home sector. Their policies on nursing homes were decentralized and fragmented. In the pandemic, they all overlooked the needs of nursing homes, and took a long time to address delays in the response (Daly, León, et al., 2022).

Research in the UK highlights that the structural separation of care into two systems negatively impacted nursing homes, as the health system was better supported during the pandemic and nursing homes were part of the social system (Daly, 2020). For example, the supply route for tests and protective equipment for the health system was much better resourced than the social system supply route that the nursing homes are a part of. Separate financial and governance procedures resulted in a hard division between both systems, making it slow to overcome the split (Daly, 2020).

EMERGING ORGANISATIONS

Several studies show the experience of emerging organisations to come in support of nursing homes. The objective in many cases was to create a link with the hospital and enable nursing homes to provide onsite care of residents with Covid-19 and to avoid hospital referrals that would be caused by organizational issues (notably lack of capacity). (Bertrand, Laurent, et al., 2020; Bernabeu-Wittel, Ternero-Vega, et al., 2021; Coulongeat, Aïdoud, et al., 2021; Fowler-Davis, Cholerton, et al., 2021; OECD, 2021)

For example, in one region of France, the emergency call services (SAMU) together with the University of Creteil, created a dedicated call centre for nursing homes. The SAMU connected nursing homes to geriatric specialists and strengthened the direct collaboration with hospitals. (Bertrand, Laurent, et al., 2020). This emerged because the SAMU, who was a gatekeeper deciding on referrals from nursing homes to the hospital, decided to take a proactive approach with calls to all 74 nursing homes in the region, to understand better what the different needs and constraints were. This led them to set up the call centre and mobilize support for nursing homes most at need.

INTERDEPENDENCIES BETWEEN NURSING HOMES AND EXTERNAL ORGANISATIONS

A UK study identified three areas of interdependencies between care homes and external organisations which impacted the pandemic response: care practices, resources, and governance (Marshall, Gordon, et al., 2021). The findings highlight the importance for authorities to engage with care homes when deciding on the response to avoid negative repercussions on these areas of interdependencies. For example, when authorities chose to centralise the supply chain of PPE, this had a counterproductive effect of taking away the care home's own capacity to manage their supplies and adapt to rapidly changing needs. The study also found that care homes which were well embedded within their communities found support from local organisations to overcome gaps.

CONCEPTUAL TOOLS: SENSEMAKING IN CRISIS SITUATIONS

Making sense of events and managing uncertainties are recurring themes for organisations in the Covid-19 pandemic. Karl Weick's (1988) concept of 'enacted sensemaking' in crisis situations describes how organisations and individuals try and figure out what is happening when faced with massive uncertainty in a crisis.

It is through actions that individuals generate understanding of the crisis. Action generates feedback on the situation which is used for reflection to understand what is happening. These actions are 'enacted' because they contribute to the construction of part of the environment, through their actions, actors bring elements of the environment into existence (Weick, 1995, p. 30). The challenge of sensemaking in a crisis, is that while actions generate understanding they also contribute to the environment, possibly making the crisis better or worse. So as one acts to understand, one also contributed to the crisis (Weick, 1988).

Weick looks at how the understanding of actions can be impacted by three elements: commitment, capacity, and expectation.

The first refers to the level of commitment given to explanations of actions in a crisis. If actions are public or hard to change, and far reaching, the justifications used for the actions will require a stronger commitment. (Weick, 1988). Strong commitments can be positive, as they can provide a common vision and direction when there is confusion. But strong commitments can also create blind spots in understanding. If strong commitments persist and are never questioned, they can become an assumption, making it hard to see if the action is damaging, as its' explanation is not questioned. (Weick, 1988, p. 310).

Capacity covers the competencies and resources that affect how an organisation or individual perceives the crisis. (Weick, 1988). The broader the view someone has the more likely they are to be perceptive of different cues in a crisis. Capacity can also be affected if decision making is centralized in upper hierarchies who are less familiar with the ground reality, taking away acting space from those closest to the operational reality:

> "The danger in centralization and contraction of authority is that there may be a reduction in the level of competence directed at the problem as well as an overall reduction in the use of action to develop meaning." (Weick, 1988, p. 312)

Finally, people's expectations impact their understanding. This means that actors' will tend to pick on cues and provide meanings that best fit their expectations, that confirms what they think they know. For sensemaking to work, when events or feedback don't correspond to what it is expected, then it's necessary to adjust expectations:

> "If you find confirming evidence, this "proves" that your hunches about the world are accurate, that you are in control, that you know what's up, and that you are safe. The continuing search for confirming evidence postpones your realization that something unexpected is developing." (Weick and Sutcliffe, 2015, p. 17).

METHODOLOGY: COLLECTING THE EXPERIENCE OF EMS AND ACTORS AROUND THEM

I carried out two sets of semi-structured interviews: a first set of interviews with EMS directors and a second set of interviews with other actors from the EMS environment, including other EMS workers and people from outside the EMS. I also reviewed documentation on cantonal policies on nursing homes and ageing, to better understand the policy and legal framework of EMS in the canton.

I focused on directors because they have the institutional overview of the EMS and are the main ones managing the institutional links with other organisations. I also included three medical supervisors from EMS as they maintain links with the medical community which is of particular importance in a pandemic.

In total, I interviewed 26 people in 24 semi-structured interviews, (two of the interviews had two people in them at the same time). 3 interviews were done using zoom, and all the other 21 interviews were carried out in person (2 at their homes and the rest in their workplaces). I added to the corpus four semi-structured interviews of EMS staff which I carried out in my previous study, as this staff had links with external actors during the pandemic (de Rivero, 2022).

RECRUITMENT

The case study I carried out the previous year in the nursing home served as a visiting card to introduce myself and this research to those I contacted for interviews.

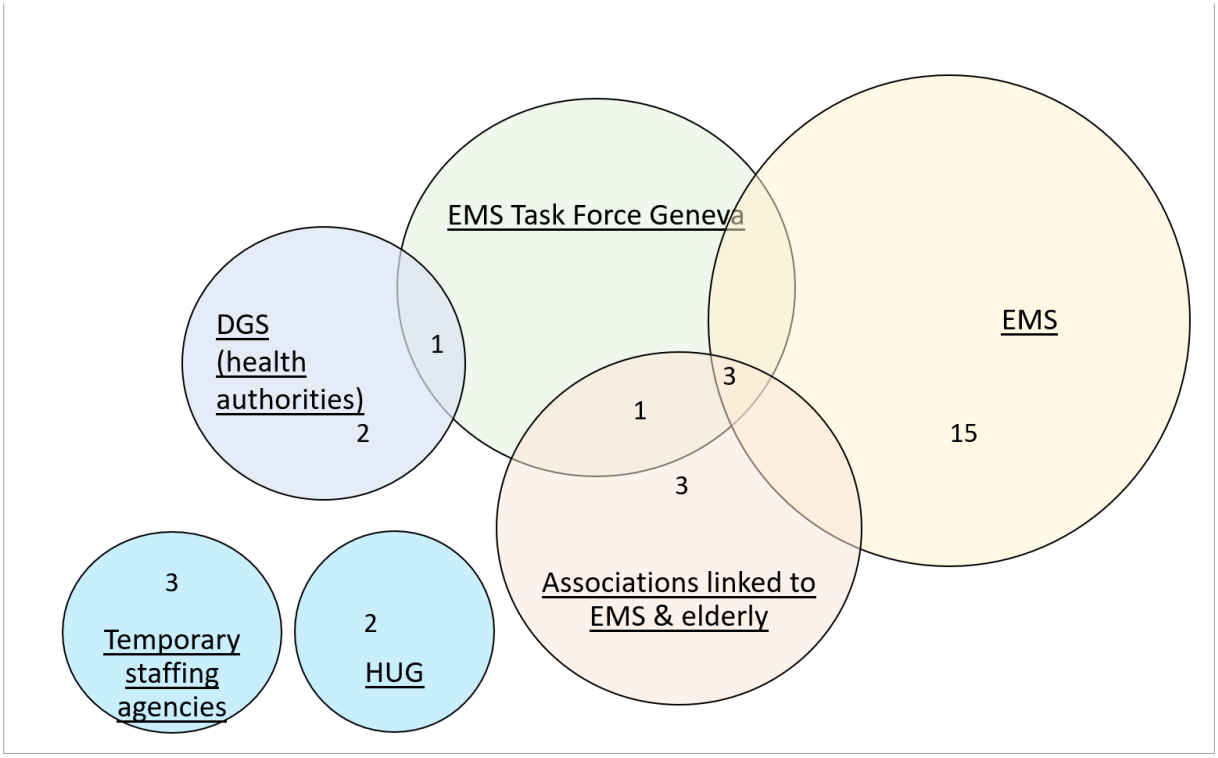
To identify the EMS directors, I contacted two I already knew, I went by word of mouth to identify seven others, and another thirteen I found online on the website of the Geneva EMS Federations (Fegems and Agems). I thought it would be useful for my reflection to have a point of comparison outside Geneva and included one EMS from Vaud. In total I contacted 23 EMS to request interviews with their directors, of which 10 accepted, and 9 were in Geneva.

To identify the other actors, I contacted actors who were commonly mentioned in interviews with the directors, actors who were mentioned by other actors interviewed, and the hospital contacts were found through medical publications linked to the pandemic. In total I contacted 20 other actors, of whom 14 accepted and 2 of them brought a colleague to the interview totalling 16 people.

PROFILE OF INTERVIEWEES AND ORGANISATIONS

In total the corpus included interviews with 30 people from 5 different types of organisations with some interviewees wearing several hats, such as working in an EMS, and being part of the EMS Covid Task Force (Figure 1).

Figure 1 - Diagram of people interviewed by organization membership



Several of the EMS directors managed more than one EMS, so they represented the experience faced in several institutions:

Profile of EMS covered from interviews with directors in Geneva	
Number of directors Geneva	9
Number of EMS covered	16 EMS (some directors manage more than one EMS)
Proportion of total EMS in Geneva	16 out of 54 total EMS
Size range of EMS	Average size 75 beds, size range 36 – 220 beds
Proportion of all EMS beds	29% of 4125 total EMS beds
Type of EMS	2 specialised EMS (advanced forms of dementia) 14 generalist EMS

In addition to the directors, the EMS staff interviews included medical supervisors, head nurses, heads of household and a head of administration and human resources.

The other actors interviewed were:

1. The EMS Federation of Geneva - Fegems (Federation genevoise d'EMS).
2. The Geneva association of family members of EMS residents (APAF)
3. The Geneva platform of associations for the elderly ("Plateforme du réseau senior")
4. The Geneva association of EMS head nurses - AGIC
5. The group of EMS medical supervisors of Geneva - MEPAG.

6. The association of EMS directors of Geneva - ADEPAG.

7. CURAVIVA – a federal level association of EMS

8. HUG - Two medics from the geriatrics department including the head of department.

9. SMC Covid Cell - Two members of the covid cell of the medical cantonal services

10. DGS - The director of the health network for the health authorities (service de réseau des soins - DGS) who is the focal point authority for EMS in the canton.

11. Two temporary staff agencies.

SEMI-STRUCTURED INTERVIEWS

On average the interviews lasted 70 minutes. Consent for the interviews was recorded orally, apart from one done by email. All interviews were made anonymous. The interviewees agreed to have their organisation listed as one of those interviewed for the research

The interviews focused on recollections of what happened in their work during the different stages of the pandemic covering the first two waves, vaccination and the wave of omicron. For each stage of the pandemic with the EMS members we explored interactions with external actors and known consequences. For the EMS, I pre-identified a few key themes and actors which I asked about if they didn't come up spontaneously. For the other actors I asked them about what links they had with EMS and how this evolved in the pandemic. (See Annex 1 for detailed structure)

CODING AND ANALYSIS

Coding was an iterative process. I started by using the pre-identified themes from the interviews, added the different actors that the EMS mentioned they interacted with, and new themes that emerged from the interviews. I finally added concepts that emerged in the analysis notably around the areas of uncertainty that the EMS faced.

To help with the analysis I looked at the three core interests that EMS acted upon to project and what uncertainties arose around them: access to resources, care provision and decision making. I then made a table with these themes and the organizational characteristics that impacted these areas (Annex 2) and how elements of the environment interacted on these themes. In a final stage I took Weick's concepts (commitments, expectations, capacities in enacted sensemaking) to see if they could be used to 'make sense' of the main findings and looked at how these main findings compared to the literature review.

LIMITATIONS

Carrying out retrospective interviews implied that people sometimes remembered things differently, in terms of dates and which stage of the pandemic certain events occurred. The beginning of the pandemic was almost two years ago. It's probable the perception of some situations and the level of details would have been different if the interviews were carried out just after the events, or while they were happening.

I was unable to clarify the extact timing of policies on certain topics that arose, such as the timing for waivers provided to EMS staff who could work if they were asymptomatic, or the exact timing of different distributions of material which were carried out.

The topic was extremely broad and I had to find ways to narrow it down in the analysis. Several interviewees mentioned the media coverage on the situation in EMS as an element of the environment. I had initially aimed to include a review of the media coverage on EMS and Covid-19 in the Canton but I didn't have the space to include this finally. However, the media coverage played an important role in feeding expectations and understanding of what was happening.

FINDINGS

The findings have been divided into two main sections. The first section, entitled 'EMS an institution of last resort' provides a general description of EMS before the pandemic, including their set up and key relations in the environment.

The second section, 'The pandemic: actions amidst uncertainty' is divided into four parts and covers the EMS in the pandemic settings:

1. First how the pandemic reconfigured the environment around the EMS with a description of the key relations and the main support actions for the EMS sector.
2. Second, the uncertainties faced by EMS and how different EMS organisational characteristics impacted the EMS capacity to manage.
3. Third, the main gaps in the pandemic response, and
4. Fourth, the tensions around decision making on regulations and protective measures.

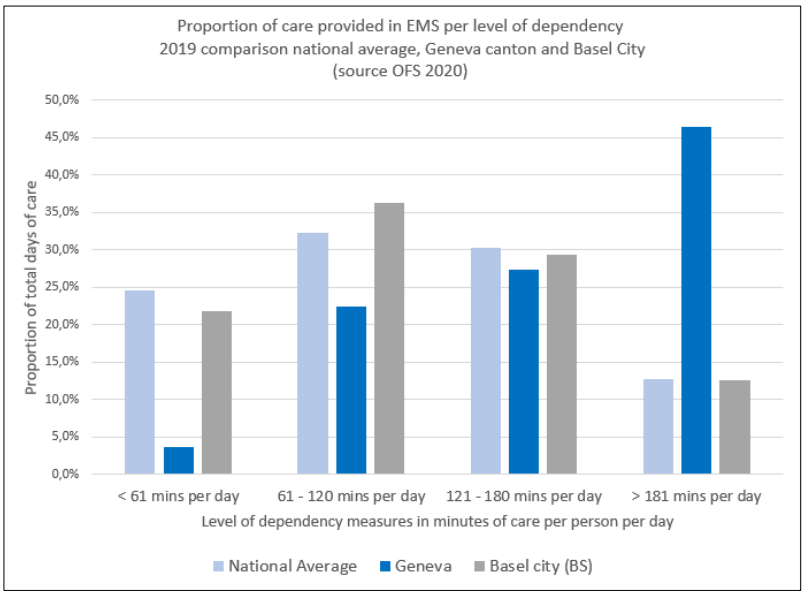
EMS IN GENEVA CANTON: AN INSTITUTION OF LAST RESORT

A POLICY TO DELAY THE ARRIVAL IN EMS

The objective of the Geneva canton's health network as defined by the law is to preserve people's autonomy, prolong their capacity to stay at home and avoid institutionalisation as long as possible (Grand Conseil, 2008). The law requires strengthening home-based care services and supporting family caregivers so that long-term care in an institution is sought only when all other options have been exhausted. Residing in an EMS is thus seen as a last resort, when hospitalisation isn't necessary and home based care is impossible (Secrétariat du Grand Conseil, 2019).

Residents of EMS in Geneva arrive at later stages in life with a higher level of dependency compared to the past and compared to most other cantons[2]. Dependency levels are measured by the number of minutes of care required per person per day. Swiss national statistics from 2019 (OFS 2020) show an average of 12.4% of total care in Swiss EMS was for residents requiring more than 180 minutes of care per day, while in Geneva 46% of total care in EMS was for residents requiring more than 180 minutes of care per day (OFS, 2020) (Figure 2). In addition, evaluations in Geneva used to estimate the loss of autonomy show a steady increase of the proportion of residents with disabilities in Geneva over the past 20 years, in particular of cognitive disabilities (Curt, 2020). These two trends suggest that the increased number of care minutes per day in Geneva is linked to the increased proportion of residents with cognitive disabilities.

Figure 2 - Proportion of care in EMS per level of dependency (source: OFS 2020)



[2] In addition to home-based care policies, Geneva canton's geography as a 'canton city' with short distances to reach the hospital makes it easier for people to live at home longer and benefit from ambulatory hospital care, compared to other cantons where distances are greater.

Transition to an EMS is often fraught with guilt by family and with grief by residents as EMS are associated with dependency, institutionalization, and death. Elderly people can see it as a failure to be autonomous and families as a failure to care for their relative. Most people who move to an EMS do so after a life changing event, frequently after a period of hospitalisation either due to an accident or illness.

Although interviewees from the EMS sector said that staying at home in old age is something they identified with, they also thought that the transition to an EMS should be seen as part of the course of life, where comfort and services are provided, rather than being defined mainly as a solution of last resort when all else fails. They said it was common to see elderly people arrive at an EMS who were socially isolated and could have benefited from arriving earlier without waiting to have an accident or being hospitalized.

> "In the end, the arrival of someone in an EMS is seen as a failure, a failure of policy for the elderly, instead of being seen as a continuation of a good policy for the elderly. There are people who can stay at home and that's fine. But there are people who are no longer comfortable in their own homes, not only for health reasons, but because of isolation and lack of contact" (Quote 1, Director EMS 1, 03/04/2022.)

DIVERSITY AND STANDARDIZATION OF EMS

There are 54 EMS in Geneva canton with a total of 4125 beds and 5160 elderly people resided there in 2020 (Conseil d'Etat, 2020, p. 180; OCSTAT, 2022). The average age of residents was 86 years old, and 73% of all residents were women (Curt, 2020). Around 5477 staff, or 4310 full time equivalents (FTE) , were employed in the EMS that year, of which 77% were women, and with an overall staff ratio of just over 1 staff per resident (OFS, 2022).

The EMS have a variety of governance structures, sizes which range from almost 30 to over 200 beds, and different styles of management and approaches to care. A small number of EMS are specialized only for elderly people with advanced forms of dementia, while most EMS are generalists who host a mixed population with a variety of ailments. Around 30 of the 54 EMS are standalone institutions, and the rest are part of groups of two to four EMS who are under the same management team.

Despite differences between EMS, they all have in common several organisational traits. EMS in Geneva are all not-for-profit institutions and have the same type of service contract with the Cantonal health authorities, with the same regulations. By law, they all must have a medical supervisor and a director who are legally responsible for the institution (Grand Conseil, 2009) . They all use the same system to evaluate care and health care costs, and grapple with similar emerging questions on care.

REGULATION OF EMS UNDER THE CANTONAL HEALTH AUTHORITY

The supervision of EMS falls under the responsibility of the cantonal health authorities, the DGS. Each EMS has a service contract with the DGS who determines the pension price per night in each EMS, the proportion of qualified staff which an EMS must have, and staff salaries are aligned to the cantonal salary scale. Each EMS must commit to have

98% or more bed occupancy and less than 6% of staff absenteeism rate. As per federal law, the State covers the part of the health care cost that isn't covered by the health insurance. The cantonal medical service (SMC) has a department of health inspectors – GRESI – who check if quality control indicators in the EMS are respected.

KEY ROLES OF THE DIRECTOR AND MEDICAL SUPERVISOR

The director and medical supervisor are legally responsible for the EMS. EMS directors arrive through different career paths, some are nurses, others come from the hospitality and service industry, or from public management. They each instil their management and organisational style, and are responsible for the overall functioning of the institution, including external institutional links.

The medical supervisors oversee that the EMS health services are well organised to provide proper care (Grand Conseil, 2009). Nearly all medical supervisors carry out this role in addition to working in their own private practice, and do not have a permanent presence in the nursing home. The personal investment in the institution varies from one medical supervisor to another. Medical supervisors may also be the treatment doctor of some of the residents, but this is up to the resident, who has the freedom to choose their treatment doctor.

PLAISIR: A SYSTEM TO MEASURE CARE AND FINANCE

PLAISIR is a programme used by all the EMS to measure the level of dependency of a resident in terms of minutes of care required per day. It is the basis of the management and financial system of the EMS. The results are used to calculate the amount of health staff needed and as a tool to bill the health insurance (LaMal) who pays part of the cost based on the level of dependency of a resident. Each resident should have a 'PLAISIR' evaluation carried out every six to nine months by a specially trained nurse. There are 12 different levels of dependency, with 1 being the level of least dependency and 12 being the highest level of dependency and requiring the most care for assisted living. Level 3 is the minimum required to be eligible to go to an EMS in Geneva, but few residents are at level 3. The largest proportion of residents are at level 12, representing 25% of all residents in EMS in Geneva in 2019 (Curt, 2019).

EVOLVING APPROACHES TO CARE: RESIDENT-CENTRED, MEDICALISED, COMMUNITY ORIENTED?

The proportion of residents in EMS who are frail, with multiple health conditions, has complexified the care demands made on the institution. Technical skills in geriatric and palliative care have been integrated into the practices of nurses who must work with autonomy, for most EMS do not have a permanent doctor present. Several interviewees voiced concerns that not all EMS are able to keep up with these rising technical demands in terms of staff training and the varying investments of the medical supervisors. A few interviewees thought that authorities need to view EMS as geriatric and palliative care centres, just a step below hospitals in terms of the level of medical care provided, and that this role should be valued more in terms of the technical and human skills it requires.

Maintaining active links with family and friends outside the nursing home and accompaniment and recreational activities, are seen as an essential part of care and of life in an EMS. Several interviewees were concerned that instituting EMS as a place of last resort coupled with the increased medicalisation of services, will encourage EMS to be closed institutions instead of opening them up. Opening EMS towards their communities would benefit residents by promoting more interactions through neighbourhood activities and would benefit the community by helping to overcome the social isolation of elderly people in the area. It would also help to reduce the stigma attached to EMS. Several directors thought that EMS multidisciplinary teams are uniquely positioned in their neighbourhoods to provide services and accompaniment for elderly people who live close by.

Several interviewees mentioned that the financial system around care is fractured along different lines, making it hard to have an integrated policy for elderly people, and representing a barrier to develop the role of EMS. For example, financing by the health insurance focuses entirely on nursing care, but care such as accompaniment is not covered. There is also a divide between financing of home-based care and institutional care, and on the social front there is division between the canton and municipalities, as activities to overcome social isolation are a responsibility of the municipality (Grand Conseil, 2016; Ionita, 2019).

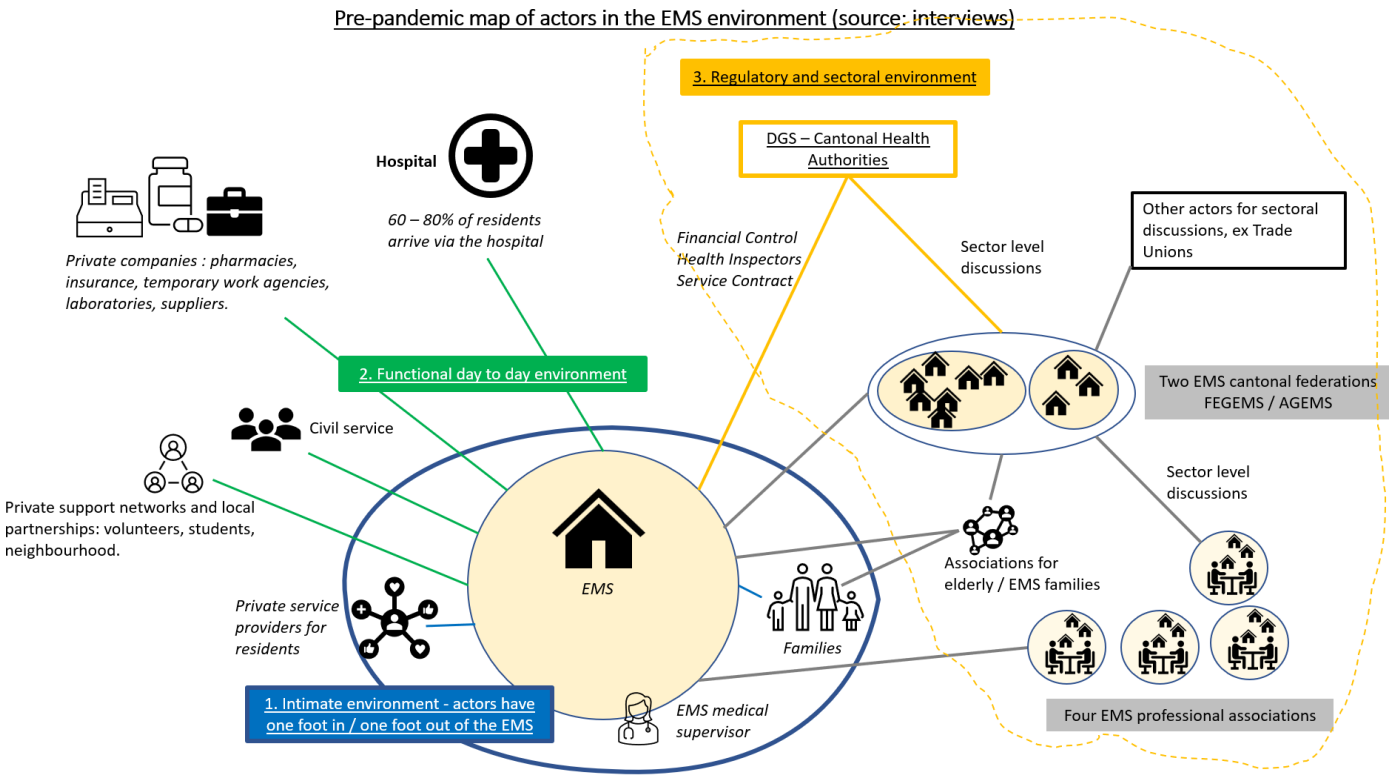
MAPPING THE PRE-PANDEMIC ENVIRONMENT

The EMS environment can be characterized through three levels of networks (Figure 3). First the 'intimate circle' includes those actors who have one foot in and one foot out of the institution and are in regular contact with EMS and the residents. These are the medical supervisors who work for the EMS and who also have their private practice outside, the families who are an integral part of the life of residents, and the private service providers who come to the EMS to provide services for residents, such as their treatment doctor, the hairdresser, or other services.

On a second level, are those institutions the EMS has links with for the running of the facility, such as the pharmacy, suppliers, or temporary staffing agencies. This includes the private support networks or partnerships with organisations for joint activities that some EMS have. It also includes actors in the health network the EMS has functional links with, notably, the hospital as a significant proportion of residents arrive to EMS via the hospital.

On a third level is the regulatory and organizational environment interacting with the EMS as a sector. These include the Cantonal health authorities, the member-based umbrella organisations EMS are a part of, the professional and other related EMS associations, and other organisations, such as trade unions, who may interact with the EMS to solve problems or on regulatory issues.

Figure 3 - Mapping of the EMS environment before the pandemic (source: interviews)



FAMILIES AN ESSENTIAL ELEMENT OF CARE

Families are part of the close-knit environment of an EMS and are a crucial part of residents' lives. Families are not a homogenous group. Some families are much more present than others, visiting or calling every day. Some residents do not have families or have families who rarely visit or who live far away. In many cases families play the role of legal guardian for their elderly parent. Since 1992, an association of family members of EMS residents, APAF, has been set up to support families and their relatives when deciding to go to an EMS, providing information and mediation services in case of a conflict.

DIFFICULT RELATIONS BETWEEN EMS AND HEALTH AUTHORITIES

Nearly everyone interviewed said that there was an estranged or distant relation between EMS and the cantonal health authorities, the DGS. Many of the directors interviewed summed up the relation as being only one of control - mainly financial and administrative control. Several of them expressed frustration saying that there was little opportunity for them to innovate or to invest in new types of projects and no space to discuss joint strategies around care for the elderly with the DGS. A few directors mentioned that the DGS managed the EMS as a standard sector but didn't acknowledge the diversity between them.

The directors see little possibilities for the EMS to evolve within the health network without joint construction with the authorities, but many interviewees believed there was a reluctance by policy makers for EMS to have additional responsibilities. The decision by the DGS not to include any EMS in the pilot project "COGERIA" launched in 2019, which aims to coordinate professional care for frail elderly people, was cited by several interviewees as an example that illustrates the exclusion of EMS by health authorities in integrated strategies around the care of elderly.

In discussions on EMS in the Geneva Grand Council, a recurring frustration raised by members of the State legislature and the executive, is the difficulty for EMS to work together to mutualise resources and find efficiencies as a sector (Secrétariat du Grand Conseil, 2019). Each EMS has their own philosophy and way of working which often deters mutualization. (Secrétariat du Grand Conseil, 2019, p. 35). Thus, on the one hand, the Canton seeks to mutualise and standardize the practice in the EMS, and on the other, EMS value their diversity as private institutions with their own organizational vision and specificities.

AUTO-REGULATION AND COLLABORATION THROUGH EMS ASSOCIATIONS

For the most part, each EMS works separately managing their day-to-day business. They also collaborate through several associations. There are two umbrella federations for EMS in the canton: the Fegems (Féderation Genevois d'EMS) and the Agems (Association Genevois d'EMS). They are both governed by their EMS members who have representatives on the governing boards. They promote collaboration between members on common interests such as training for staff, sharing best practices or mutualisation initiatives. They also act as a sectoral representative of the EMS vis à vis the Cantonal health authorities and other actors.

There are four professional associations of EMS in Geneva: for EMS directors (ADEPAG), for medical supervisors (MEPAG), for head nurses (AGIC), and for the heads of housekeeping (API). These associations share best practices and experiences they collectively face in EMS, and some also play a role to regulate their profession in the sector. For example, the MEPAG defined the necessary qualifications and hiring process of the medical supervisors in an EMS. The ADEPAG has worked on negotiating the directors' salaries with the Canton and has developed a frame to regulate the directors' work such as salaries and work hours. The AGIC, for head nurses, has focused on sharing common concerns such as on the evolution of care practices or the use of PLAISIR.

There are different expectations of the role of the EMS Federations. Interviewees said that some EMS directors are reluctant for the EMS Federations to regulate and standardise the sector, as this takes away flexibility and freedom of action from what are essentially private institutions. Other directors think that EMS Federations should do more to pool resources and reduce costs in the sector; processes which will engender more standardisation. Several directors regret that the Fegems and Agems aren't included in higher level policy discussions with the Canton health authorities. Meanwhile, in the Geneva Grand Council hearings, some legislators and state representatives voiced frustration that the EMS federations couldn't enforce more mutualisation between EMS to cut down costs (Secrétariat du Grand Conseil, 2019).

WEAK RELATIONS IN THE HEALTH NETWORK

Administratively, EMS sit within the Geneva health network. Nearly all of those interviewed in Geneva described the EMS as being on the periphery of the health network. Many of the directors described a lack of contact and hardly any collaboration with the main home-based care service, the IMAD. Despite some functional links with the hospital, as 60-80% of residents who arrive in EMS come via the hospital, there is no collaboration with the HUG outside direct referrals. Interviewees attributed this peripheral situation of EMS' position as a result of the contradiction of being part of a network whose objective it is to keep people away from EMS, as the main objective of the health network is to delay the arrival of people to the EMS.

One EMS director saw their EMS as actively part of the healthcare network, with several initiatives and projects with the HUG, and other actors. The director acknowledged that this was largely because of many personal contacts within the network, but also because the director took the initiative to reach out and develop partnerships. But admittedly the interviewee said this was not representative of EMS in the sector.

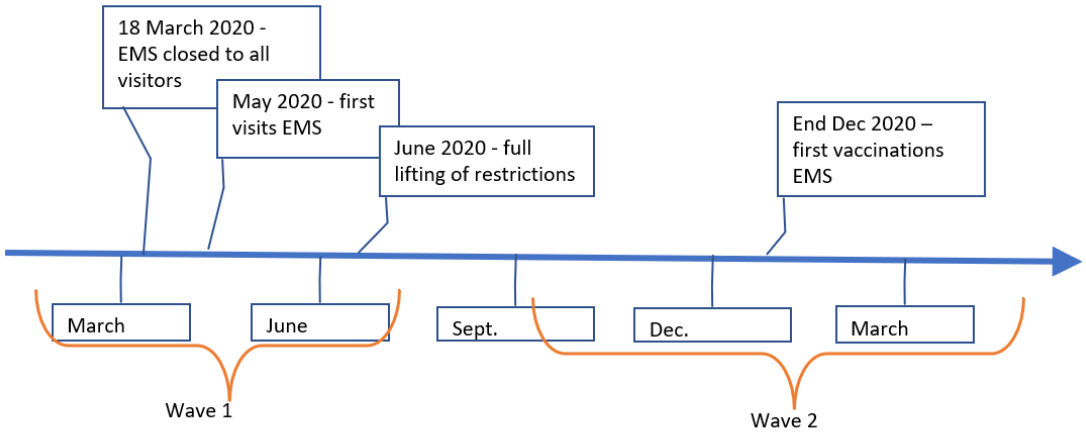
THE PANDEMIC: ACTIONS AMIDST UNCERTAINTY

Extreme uncertainty was a defining characteristic of the pandemic outbreak. Little was known about the virus and the disease, about the risks of reinfection or the proportion of people who were asymptomatic. One of the few things that was known from the beginning was that elderly people were at risk of developing acute forms of Covid-19. There were few tests, no vaccines and no treatment, and there were general shortages of protective material such as masks and disinfectants. Uncertainty was most acute the first year and improved over time as experience increased, with vaccination and tests being the main game changers in reducing uncertainty and improving pandemic outcomes.

The overall objective of the pandemic response was to protect the vulnerable and slow down the rate of transmission to avoid overwhelming hospitals with a large number of acute Covid-19 patients. (DSPS, 2020). At the hospital level, the Canton's response strategy was to centralise all hospital resources of the canton to make the HUG (University Hospital) the treatment centre for Covid-19, diverting most other types of patients to other clinics. (Conseil d'Etat, 2020, p. 180)

On 16th of March 2020, the Federal Council of Switzerland declared an extraordinary situation invoking the epidemics act to put in place social distancing measures and partial lockdowns. The management of EMS is a cantonal responsibility, and each canton emitted specific regulations for the EMS. In Geneva canton, external visits to EMS were prohibited on March 18th 2020. A few visits started in May with appointment, but restrictions were not completely lifted till end of June 2020. After a lifting of restrictions over July- September 2020, the second wave saw a semi-confinement, schools remained open, and EMS were not systemically closed to visitors.

Figure 4 - Simple timeline of the two waves of the pandemic in Geneva 2020 - 2021



A RECONFIGURED ENVIRONMENT: ACTOR MAP AND KEY RELATIONS

For the EMS, each wave represented a heightened exposure of Covid-19 entering the institution, and an increased risk of facing shortages of material or human resources, particularly before vaccinations were rolled out. The three levels of the EMS environment were impacted by the pandemic (Figure 5).

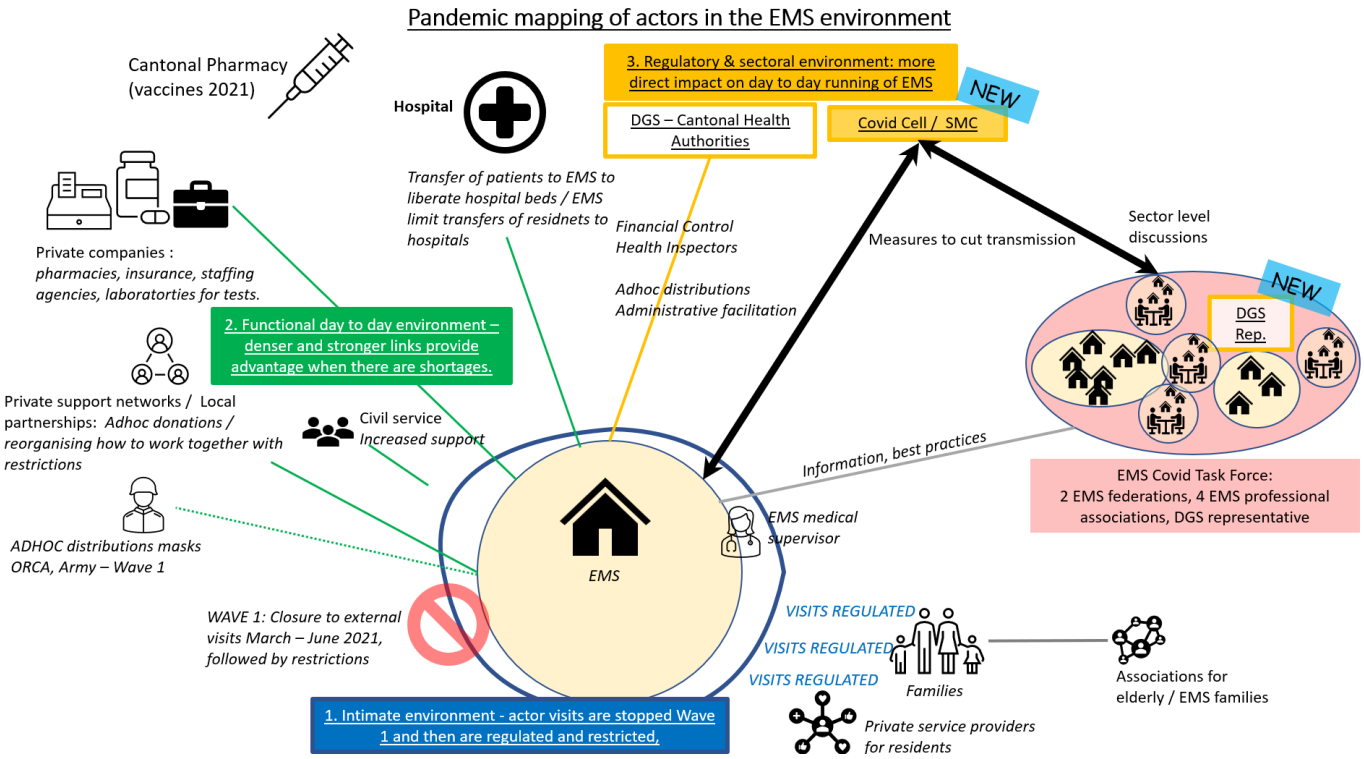
Except for the medical supervisors, actors in the 'intimate circle' – those who have one foot in and one out of the EMS - were physically cut off from EMS in the first wave, and then subject to restrictions and regulations in the following period. Many of the service providers, including in many cases the residents' treatment doctors, stopped going to the EMS during the first wave. Relations with families happened virtually and then faced restrictions in the following waves.

On a second level, in the functional environment, when there was an epidemic peak the EMS and other actors in the health network would compete with one another when there were general shortages or high demands for staff. New actors appeared on an adhoc basis for specific actions, such as the army and ORCA who carried out distributions of material, or the civil protection and Cantonal pharmacy who intervened for the vaccination campaigns. The general objective of protecting hospitals from being overloaded reconfigured the link between EMS and hospitals.

In the third level, the links with the regulatory and sectoral actors - the health authorities and EMS associations - gained prominence during the pandemic and impacted the day-to-day matters of the EMS. There was increased information exchange across the sector, notably through the creation of an EMS Covid Task Force, and increased operational measures and regulations linked to the pandemic response.

During Covid-19 outbreaks in EMS, links to the outside world in all three levels of the environment were reduced. External links mainly focused on communicating with families, finding staff replacements, and carrying out tests. In addition, there were links with the Covid Cell of the SMC on strategies to cut transmission and to collect data on the outbreak.

Figure 5 - Mapping of the EMS environment during the pandemic (source: interviews)



EMS TASK FORCE: EMERGING ORGANIZATION TO MANAGE UNCERTAINTY

The EMS Task Force arose organically, without having been planned, when the EMS sought solutions as a sector facing the pandemic. The composition of the EMS Task Force was unique, bringing together both EMS federations, all the EMS professional associations and the director of the health network of the DGS (cantonal health authority). It allowed for different expertise to be deployed and to have a direct channel to EMS and to authorities. After the first year and once the vaccination started, this role gradually dissipated, until it was put on standby.

The idea began by the end of February 2020 when many EMS turned to the EMS federations, notably the Fegems, with questions on how to prepare for the pandemic and to alert on the shortages they faced of masks and disinfectants. At this point there was no guidance coming from authorities for EMS. For some EMS interviewed one of the motivations for the Task Force was the concern that authorities might impose blanket restrictions not adapted to EMS realities if the EMS didn't coordinate quickly as a sector:

> "I told myself that we had to coordinate all of this because it was going to be extremely difficult if each EMS, had to deal with the pandemic on its own. If we waited too long, it would be the cantonal medical service, that doesn't know EMS who would put down rules and directives that we wouldn't be adapted.." (Quote 2, Director EMS 9, 23/06/2022.)

On the 12th of March 2020 the EMS Covid Task Force was set up at the initiative of the EMS sector, just as the first confirmed Covid-19 cases appeared in EMS in Geneva. The objectives were to coordinate a response to needs and questions coming in, to cen-

tralize information on what was happening in the EMS, and to help develop an adapted response to the reality of the EMS.

For the director of the health network from the DGS this was a precious way of being aware of what was happening on the field, of keeping the higher levels of the Canton's Health administration aware of the practical realities, and of helping to develop a coherent and coordinated response for nursing homes. Several of the Task Force members highlighted the benefits of having a member of the health authorities join the EMS Task Force:

> "It is the only time when I've seen all the different associations get closer to each other and with the State. Often, when we are in touch with the state, it is either because they have new rules, that we must apply, or because we have a complaint to escalate. But here, we really worked together." (Quote 3, Member EMS Task Force, 18/05/2022.)

The EMS Task Force met every day and became the focal point for all questions coming from nursing homes in the Canton. This was a time when the measures evolved constantly, uncertainty was high, and practical experience was evolving. The first concerns raised by EMS was around access to materials, how to adapt protective measures to EMS settings, adapt protocols for care of residents with Covid-19 and how to manage the closure of nursing homes to external visits. According to the Fegems 2020 annual report, that year the Task Force fielded 600 questions from EMS and sent over 76 newsletters (or 'info emails') to all nursing homes, with centralised updates and replies to questions (Fegems, 2020).

Measures and recommendations would be announced by the Federal and Canton medical authorities (SMC). The EMS Task Force would then contextualize the generic recommendations to EMS realities, and act as a focal point for EMS. The Task Force provided an overview of what was happening in the whole sector. They also organised distribution of material, including sharing of material between EMS.

The EMS directors interviewed highlighted the value of having people from the EMS sector be part of the Task Force, as they could understand the issues that arose. Several directors noted a shift in the EMS Task Force by the end of 2020 and said that replies were no longer as tailored to the EMS as they had been in the past, nor as reactive. One director explained this shift by saying that the most active members of the EMS Task Force, were exhausted, and had to take a step back. Another explanation was that the added value of the Task Force resided in the first wave when there was an avalanche of questions and shortages of material, and that this need waned down by the time the second wave arrived. In September 2020, the Covid Cell of the Cantonal Medical Service (SMC) had formed a team specifically to help follow up with EMS, this team liaised with the EMS Task Force, and the health authorities started to take a more prominent role in providing answers for the sector.

By 2021 the EMS Task Force met less frequently, until the members decided to put the EMS Task Force on standby. All questions then had to be fielded directly to health authorities. The reasons for this weren't necessarily communicated about or understood by other EMS directors.

Other sectoral networks were also used for support. For example, the association of medical supervisors– MEPAG - communicated with each other regularly throughout the

pandemic, and their representative in the EMS Task Force was a conduit between the EMS Task Force and their association, including on quality of care issues.

HEALTH AUTHORITIES: FROM ADMINISTRATIVE REGULATION TO CRISIS RESPONSE

The health authorities were the lead actor in the pandemic response while the EMS became one of the places most at risk of being directly impacted by Covid-19. The relationship with authorities shifted from a bureaucratic one of administrative regulation to an operational one where pandemic response measures could have a direct impact on the day-to-day running of the EMS. A major concern for EMS was that the specific situation of the EMS sector be acknowledge in the pandemic response.

A first characteristic of this reconfiguration is that the EMS sector and health authorities had to jointly manage pandemic uncertainties, including the uncertainties of what to expect from one another. Both the health authorities and the EMS learnt as the pandemic unfolded, through their own actions, and their interactions with one another. One of the Task Force members from an EMS described it the following way:

> "We were learning as we went along in the crisis. Every day, we faced new situations which appeared. Sometimes there was a delay at the State level to give new recommendations. They were moving along like us". (Quote 4, Member EMS Task Force, 18/05/2022.)

A second characteristic is that the main link with health authorities shifted to the SMC (Cantonal medical authority) who oversaw the pandemic response and this link became more formalised over time. In the beginning the SMC didn't have a dedicated team to follow up with the EMS. When the first Covid-19 case was confirmed in Geneva, the SMC only had a couple of people for the follow up of infectious diseases and had to rapidly build their capacity through the creation of a dedicated Covid Cell. Initially there weren't any dedicated resources to follow the specific situation of EMS and there was constant turn over between the people who would liaise with EMS. EMS directors describe receiving repeated calls from different people asking for the same type of organisational information such as the EMS size and contact details of staff. There appeared to be no centralised information or follow up.

In September 2020, the SMC Covid Cell created a team dedicated to clusters in EMS, to help with contact tracing and strategies to cut transmission, and they set up a standard system of reporting to collect data on Covid-19 tests from all EMS. Links were also formalised through the protection plans. Protection plans described the measures in place in an EMS and served as a communication tool with family and staff. The first protection plans were done spontaneously by EMS in the first wave to prepare for different scenarios. By the second wave the protection plans became a tool of regulation by the SMC. The EMS updated the protection plans when new Canton recommendations came out, and then sent the plans to the SMC for validation.

A third characteristic was the concern in the EMS sector that authorities be aware of the specificity of the EMS sector. This concern was also a Federal one. During the first wave, the federal association for EMS, Curaviva, contacted the Federal office for public health (OFSP) asking to be a part of Covid-19 discussions so that quality-of-life concerns

be considered by policy makers when working on pandemic response plans. The main worry both at federal and cantonal level was that the pandemic response be driven by the objective of cutting viral transmission without integrating the realities of institutions where people live - such as nursing homes, or homes for people with disabilities - where emphasis is placed on social ties, accompaniment, and valuing individual care. A purely technical approach to cutting transmission risked reinforcing the institutionalization of people living in collective long term care settings.

A fourth characteristic is that certain actors played a key role as brokers to bridge between the EMS and SMC systems. This included the EMS Task Force members, and bilaterally, the medical supervisors, the EMS directors, the director of the health network who was in the task force and some members of the SMC Covid cell dedicated to EMS. Through the interviews there were many anecdotes on specific people who managed to mediate and find solutions around a measure that was considered either too strict or not strict enough. The medics tended to have a role of authority as specialists within the pandemic, with several examples of medical supervisors discussing with the SMC on a 'doctor to doctor' basis to find solutions.

Finally, many of the EMS interviewees said that the capacities and needs varied between EMS, and that some EMS faced great difficulties and needed more support than others. The EMS Task Force centralised information on shortages in the first stage of the pandemic, but this was an adhoc and reactive endeavour. The SMC Covid Cell focused on reducing transmission during an outbreak, but not on other types of needs. It is unclear how aware authorities were of the different needs that existed, or if there was a mechanism for health authorities to assess the different needs of EMS throughout the pandemic and to provide tailored support.

FAMILIES AT THE CROSSROADS OF COMPETING PRIORITIES

Families were seen both as an essential lifeline for residents and as a potential risk for Covid-19 entering the institution. For almost two years, until February 2022 when the covid passes were lifted, family visits were regulated through restrictions of varying degrees. Both staff and families witnessed how isolation could deteriorate a resident's autonomy and motivation. Families found themselves at the crossroads of sometimes competing priorities for the EMS: reducing the exposure of nursing homes to the virus or promoting family links.

An extreme example of this, is when family members were not allowed to visit their dying relatives during the confinement in the first wave. Several directors describe not allowing these visits to take place, because they thought that's what they had to do. They all describe this decision as inhumane and said that they decided against following such restrictions. I was unable to confirm whether that was a sectoral decision or whether it was managed by each EMS.

The directors interviewed all raised the importance for the EMS to strengthen communications with families. They sent regular updates on what was happening in the EMS and the new measures in place. According to the interviews, this communication was generally appreciated by families, but there were also families who were very upset with the restrictions imposed and all the directors describe receiving insults. Some families, or residents (and a few directors) reached out to the association of families of EMS residents

(APAF) to ask for their help in mediating. Some directors found that using official policies to justify strict measures, helped to give them validity when there were complaints from families.

When family visits resumed, staff found themselves playing the role of 'health police', controlling families, to make sure they followed protective measures. Rules changed regularly, such as how often families could visit, how many could visit, whether they could touch, whether they could share a meal together, whether they could visit in the resident's room, among others. This could be an uncomfortable role for staff as it changed the normal way of relating to families. The role was played to different degrees depending on the EMS and on the individual staff members, with some being much stricter than others.

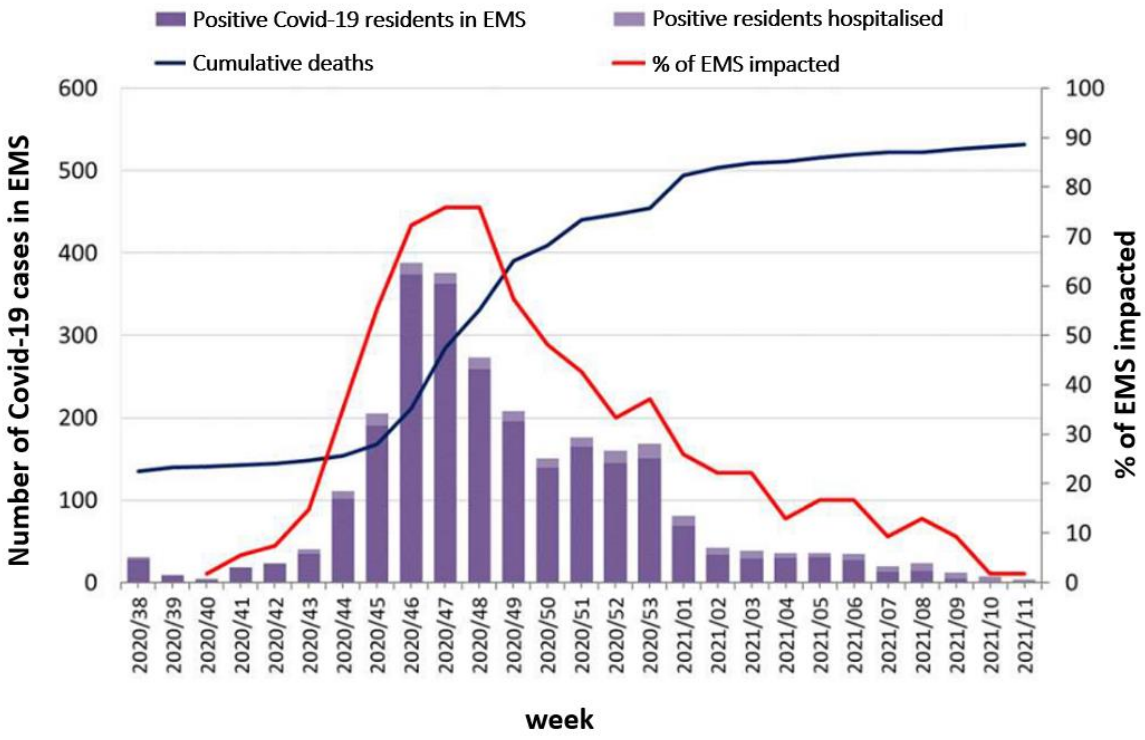
A few interviewees regretted that the EMS didn't close again to visits after the summer of 2020 and felt that this explains why so many EMS had big Covid-19 outbreaks in the second wave. Other interviewees thought that visits should never be stopped again, illustrating the different views that still exist on this issue.

EMS AS INSTITUTIONS OF RESILIENCE FOR THE HEALTH SYSTEM

The EMS position shifted from being in the periphery of the health network, to collectively playing a central role in the pandemic response. Collectively, the EMS became an important player in providing care to elderly people with Covid-19. When there was an outbreak, a big part of the work was to care for residents who were sick (as well as those who were not sick) and relatively few residents were transferred to hospitals. At the same time, hospitals transferred elderly non-Covid patients to the nursing homes to free hospital beds to manage an influx of Covid-19 patients.

All people interviewed from the EMS say that in practice referral to hospitals was rare. As can be seen in figure 4-2 below, extracted from the weekly epidemiological report by the SMC (SMC, 2021, p. 16) only a small proportion of Covid-19 positive residents were transferred to hospital in the second wave.

Figure 6 - Covid-19 positive residents in EMS and hospital, second wave (source: extracted from SMC 2021 p. 16)



One of the doctors from the HUG geriatric ward described how throughout the whole pandemic they were aware that EMS were taking care of many patients with Covid-19. Most of the elderly Covid-19 patients received in the hospital were coming from their private homes. For elderly people at home the only choice they had if they needed round the clock care was to go to hospital, they didn't have an intermediary place like an EMS.

> "We noticed on a daily basis that the EMS kept their patients and managed them on site as long as they could, as long as the patient's situation allowed it, they even set up palliative care when it was necessary. It was extremely clear that in all the waves we had few patients coming - everything being relative - but few patients coming from the EMS, and the patients who were hospitalised came mainly from private homes. That was very clear, and they really played the game to keep the patients as long as possible in their usual place of residence. That was evident to us. (Quote 5 Dr Y, Geriatric Hospital, HUG 20/06/2022)

The primary two reasons which were given for not transferring residents with Covid-19 were that the transfer to a hospital would have been of little or no added value to the patient, and in cases where it could have been of benefit the resident and/or the family often didn't want the referral. A few interviewees mentioned cases of families insisting for a referral which was then carried out. A third reason given by one EMS interviewed for not transferring residents was that at one point during the second wave in November 2020 the hospital was full and asked the EMS to keep the residents.

There were also organizational criteria for referral: if the EMS didn't have enough health care staff to take care of patients, or if the nursing home didn't have enough oxy-

gen. However, no concrete examples came up where this happened. One of the medical supervisors described it this way:

> "We quickly realised that the limiting factors were the availability of staff and oxygen in the EMS. If I don't have the staff to stay overnight and if I don't have the oxygen, then we need to transfer, because it's the hospital that has plenty of oxygen and that has gathered all the staff. So it was as simple as that: oxygen and staff . (Quote 6, Medical supervisor Dr A, ITV 05/05/2022)

Aside from the case-by-case reasoning on referrals, there was also an overall background objective to not override the hospital system, and to privilege on site treatment, in as far as this care could be provided

In addition to providing onsite treatment for Covid-19 patients, the EMS also took in residents from the hospital to free hospital beds. In 2020, a total of 398 patients were transferred to EMS in this way (Prieur, 2020). This allowed the HUG to have more capacity to take care of Covid-19 patients, and at the same time after the second wave, it supported some EMS in increasing their bed occupancy at a time when they started facing financial difficulties following many deaths due to the pandemic and few new residents arriving in EMS.

ACTIONS TO SUPPORT EMS: A FOCUS ON PROTECTION AND PREVENTION MEASURES

The support available to EMS focused on strengthening protective measures in the nursing homes, including to stop transmission when there was an outbreak. Vaccination of residents was prioritized by the Federal and Cantonal authorities end of December 2020, while vaccination of staff came a little later. The cantonal pharmacy organised the vaccination and provided support and training to carry it out.

Distributions by the EMS Task Force, DGS, and other actors

Of the 9 heads of EMS interviewed in Geneva, 7 of them mentioned shortages of materials in the beginning of the first wave. The EMS Covid Task Force played an important role in distributing material to EMS at the beginning of the first wave, and in redistributing stocks of supplies between them. Thanks to the coordination by the EMS Task Force other entities who later carried out distributions – such as ORCA, the Swiss Army, or the DGS - were able to have an overview of the needs from the EMS side. According to the annual report by the Fegems, the EMS Task Force and the Fegems coordinated the distribution of 400,000 masks, 25,000 gowns and 11,000 liters of disinfectant gel in 2020 (Fegems, 2020).

Financial support for material by DGS

Financial aid was also available to all EMS during the pandemic to buy communication material (such as tablets) and through a lump sum per bed and per day, to cover the costs of masks, disinfectants and plexiglasses. According to the Canton's annual reports 4.3 million CHF of supplementary subsidies were provided to EMS in 2020 and 2021 to pay for additional costs incurred in the pandemic. (Conseil d'Etat, 2020, 2021). In addition the

DGS temporarily lifted some of the standard regulations EMS are subject to in their service contracts, such as the need to have a minimum bed occupancy of 98%.

SMC Covid cell support to cut transmission

From the second wave the SMC Covid cell had a dedicated team to follow up on clusters in EMS. They who worked with the head nurse or medical supervisor to decide on actions to cut transmission, carry out contact tracing, and decide whether to carry out collective screenings and if needed the IMAD was mobilised to help with testing.

Global measures which benefit staff management

Certain cantonal responses to the pandemic which benefited all health staff or the wider population, also helped solve staffing issues for nursing homes. For example, the provision of badges to give health staff priority to cross the border from France was an immense benefit to nursing homes, as it was for all health structures in the Canton. The reduction of isolation time for Covid positive cases from 10 days to 5 days was mentioned many times as making a huge difference to manage staff absences.

Civil service support

Nearly all EMS describe the civil support service, known as 'civilistes', as a major source of help. Many EMS regularly had civilistes joining their teams before the pandemic. This increased during the pandemic, with civilistes helping with a variety of tasks, from disinfection, to helping organize family visits. One of the larger EMS interviewed had 160 civilistes come in the first wave of the pandemic to take the residents out for walks in the park.

MANAGING AREAS OF UNCERTAINTY: ORGANISATIONAL VARIABLES AND GAPS IN THE RESPONSE

This section will look at the uncertainties that arose with the pandemic and the organisational variables the led to differences between EMS, and the gaps that remained in the response.

EMS AREAS OF UNCERTAINTY: ACCESS TO RESOURCES, CARE AND DECISION MAKING

In the interviews, EMS members describe their actions in the first year of the pandemic as being constantly reactive to the unfolding situation, managing each new problem as it arose, and learning by doing. The uncertainties they faced can be grouped into three organisational areas of concern they tried to protect: uncertainty on access to resources, uncertainty around care and protection (including in case of a Covid-19 outbreak) and uncertainty around decision making.

Figure 7 - Three organisational areas impacted by uncertainty in EMS (source: interviews)

Access to resources	Access to protective material, to medical supplies, and to human resources, impacted the EMS ability to protect and provide adequate care to the residents. Uncertainty around resources fluctuated throughout the pandemic and depending on the EMS. When access to resources was in short supply in the general context, then it was the strength of the formal or informal networks that nursing homes had which came into play.
Provision of care	The provision of care represents the organisations 'raison d'être', their social mission. The pandemic brought uncertainty to this role by the tension it created between protective measures and quality-of-life issues and the daily organisational challenges of reorganising the EMS to provide care. Uncertainty was high when there were outbreaks. The rapid infection of staff and residents required making concessions on care delivery for residents including accompaniment in end-of-life care.
Decision making	This concerns the capacity to make decisions that are adapted to the ground realities of the EMS. Uncertainty on decision making was at its highest at the beginning of the pandemic when everything was new, recommendations from the health authorities were constantly changing, and EMS teams were trying different ways to implement protection measures. To a large extent, the EMS Covid Task Force acted as a mitigation mechanism to help reduce these types of uncertainties by sharing best practices and providing advice to on how to adapt measures to EMS realities.

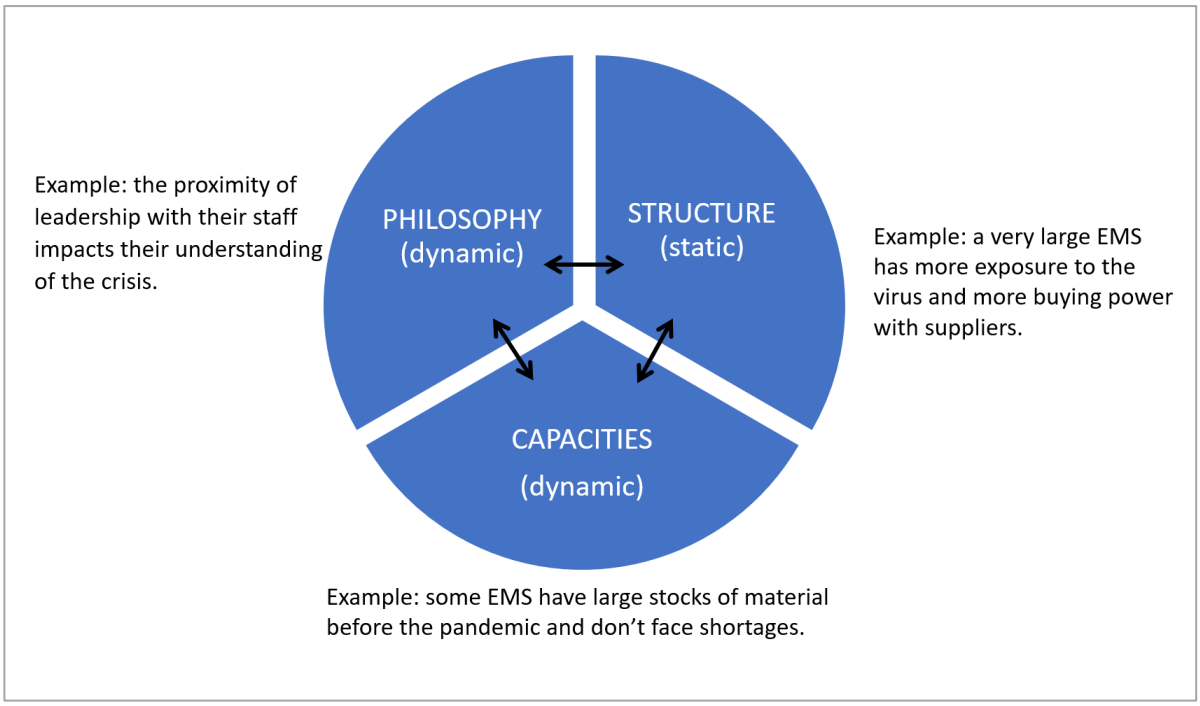
EMS ORGANISATIONAL VARIABLES ALSO FRAME THE RESPONSE

The extent to which the pandemic created uncertainty also depended on certain organisational characteristics of the EMS. From the beginning of the pandemic a variety of characteristics led to differences between them. The characteristics can be grouped into three types of organisational variables: structural characteristics; the capacities of the EMS; and the EMS organisational philosophy.

The structural characteristics tend to be hard to change, such as the buildings, the size, or the type of EMS (specialised for people with dementia or generalist). Some features can be both an asset and a constraint, for example, the director of a large EMS felt that the EMS had a high risk of being exposed to the virus, but also had a much better bargaining power with suppliers when ordering material during shortages compared to a small EMS.

Capacities of the EMS are the different types of resources an EMS can mobilise, such as material resources, the support networks an EMS has, or the background and expertise of its staff. Some of these capacities may fluctuate throughout the pandemic. For example EMS had large stocks of masks from the beginning of the pandemic. Some capacities tend to be static, for example some directors have a nursing background which they said was helpful when supporting nursing teams with the Covid-19 protocols.

Figure 8 - EMS organisational variables in the response (source : interviews)



The philosophy is the approach that the management team has towards the services they provide and the organisational investments they make. This led to differences on how risk was evaluated and managed in the EMS, and on how the EMS balanced protection and isolation measures with care for residents. Some EMS found that restrictive measures gave them a sense of security and reduced uncertainty, whereas for others, re-

strictive measures on residents undermined their visions on care and created other uncertainties on outcomes for residents.

Several trends come across when seeing how these variables interact with the pandemic environment to create differences in access to resources, provision of care and decision making (detailed table in the Annex 2).

Grouped EMS have more flexibility than standalone EMS.

Of the nine EMS directors interviewed in Geneva canton, six of them manage a group of two or more nursing homes. Those EMS who were grouped under the same management functioned like small networks that provided practical support to one another. For example, stocks of masks or oxygen bottles in one EMS in the group could be mobilised to compensate for shortages in another one. This was possible in as far as there were no simultaneous Covid-19 outbreaks in the EMS who were part of the same group. This didn't necessarily stop them from having general shortages at the beginning of the first wave. One EMS interviewed outside Geneva Canton is administratively part of a hospital group and could count on the hospital for supplies of material, staff support, and Covid testing of staff, from the beginning.

Long term contracts and anticipated bulk supply orders helps avoid shortages

Those EMS who had large stocks at the beginning were more likely to avoid shortages. Some EMS anticipated supply orders to avoid shortages, such as renting oxygen concentrators in case there would be shortages. One director of a large EMS recounted making advanced bulk supply orders with five different companies at the beginning of the pandemic to make sure they never faced shortages. Another EMS director from a small EMS said they were at a disadvantage during shortages because companies would prioritize the larger structures and leave smaller EMS waiting. It's not possible to know whether the bulk supply orders by some created shortages for others. Some EMS also mentioned that long standing contracts meant that companies were more likely to try and meet their needs. One EMS director interviewed was convinced that the problem was not one of shortages, but of being able to pay the price. While other actors also acknowledge the increase in prices, they clearly described difficulty to find certain items, including the geriatric ward in the HUG recounted facing shortages of material.

Facing staff shortages : temporary staff agencies and alternative networks

At the peak of staff infections, when there was an outbreak inside the nursing home, temporary staff in some EMS became the main source of staffing with a high turnover amongst them. Some EMS describe never having a problem to find staff through agencies, others struggled in the second wave, and one EMS asked infected staff to come back to work before completing isolation. It's possible that those who had standing agreements with temporary staffing agencies had less trouble finding replacements. Some directors describe the infections amongst staff being spread out over time, making it easier to manage.

Three of the EMS directors interviewed didn't rely on agencies. All three had made an organizational choice in the past to not use temporary agencies, because they wanted to create a family atmosphere in the EMS, building a pool of people who are familiar with the residents. This gave them a degree of self-sufficiency during the pandemic, and they were not impacted by the competition between all the health actors – clinics, hospitals and EMS – for health staff during the second wave. However, all three of these nursing homes were either relatively small or reportedly had very few staff who became infected at the same time. It's possible this self-reliance would have been strained if they were in larger nursing homes or if greater numbers of staff would have been infected all at once.

Different level of involvement of medical supervisors in EMS.

Over the course of the pandemic, some medical supervisors focused entirely or mostly on the EMS they followed and were very present when there was a Covid-19 outbreak. However, several interviewees mentioned that there were also EMS who had medical supervisors who were largely absent from the EMS including during the outbreaks In the examples mentioned in interviews, the solutions that were often found depended on informal support, but there appears not to have been any mechanism to provide this type of extra support to a nursing home who needed it. It's not clear how many EMS faced this difficulty.

Different approach to isolation measures

The extent to which EMS used restrictive measures could also impact the capacity of the EMS to have a comprehensive approach to care of residents. Measures which reduced residents' social links and disrupted their lives over a sustained period, had a deleterious effect on the residents' health. Nearly all interviewees speak of cases of elderly residents who shut off, lost motivation and mobility, and even some who just seemed to let go of life and die. Closing nursing homes to external visits for three months was a contributing factor, but so was changing their rituals and habits, putting them into isolation in their rooms during an outbreak or in quarantine when arriving at the nursing home, or being unable to have physical contact family members who visited, among many other restrictions.

FALLING THROUGH THE GAPS: UNMET NEEDS IN RESOURCES AND CARE PROVISION

PROVISION OF CARE : NO EXTERNAL BACK UP FOR COVID-19 CARE

Resources for providing care to people with acute forms of Covid-19 focused primarily on hospitals. The EMS prepared themselves, the association of medical supervisors (MEPAG) and EMS Task Force, were in touch on protocols and quality-of-care issues particularly as questions came in from EMS at the beginning, but it was mainly something the EMS had to be self-sufficient about. For example, there was no systemic solution for EMS who needed sedatives during the first wave, when there were market shortages after sedatives were concentrated in the acute hospital services. A medical supervisor who had

to manage an outbreak in the first wave felt very isolated with little back up on issues to do with care.

Interviewees from the geriatric department describe a large level of support they had from the HUG, which helped them calibrate their care for patients. These sorts of resources weren't organized around EMS, although they became a care provider for Covid-19 patients when there were outbreaks during the first and second waves. In the interviews this wasn't mentioned as a general unmet expectation, and none of the people interviewed were under the impression that there were systemic resourcing problems with care delivery that needed fixing, but throughout the interviews specific situations were mentioned where support would have been needed.

STATUS OF EMS STAFF WAS NOT ALWAYS CONSIDERED 'ESSENTIAL STAFF'

A few interviewees mentioned that the status of EMS staff as 'essential staff' by the SMC varied over time impacting whether they had to isolate when they were a contact case or if they could go to work if they were asymptomatic when there was a surge in Covid-19 cases. There wasn't clarity in the interviews why there was this variation, but when staff were no longer considered "essential staff" in the response it had implications on planning and resourcing. At times it required one-to-one discussion with the SMC for exemptions to allow EMS staff to work.

GAPS IN ADDRESSING RESOURCE PROBLEMS THAT ARE NOT WIDESPREAD

There was no mechanism in place to help manage issues that affected a few EMS, even if it affected them gravely. Some work insurance companies didn't acknowledge Covid-19 as a work-related illness for EMS staff who were not health workers in some EMS. The EMS Task Force recommended that EMS make an appeal to the insurances who failed to recognize the role of non-health staff. The EMS who were impacted thought this could be managed as a sectoral issue.

Another example is the financial impact of having a low bed occupancy after the second wave. The excess mortality during the pandemic period in EMS coupled with a lower number of new residents arriving, led to a reduced bed occupancy which ranged between 5% to 30% of empty beds depending on the EMS. (Fegems, 2021). At least three directors covering 6 EMS of the 16 interviewed, struggled to make ends meet. Those who were not impacted said it was either because they had enough reserves or because enough new temporary or permanent residents arrived.

Measures proposed by the Canton were insufficient to cover the losses for some EMS. To avoid firing staff as other EMS had done, those interviewed found ways to cut on costs., Vacancies were left open and temporary replacements staff were not used. In one nursing home, care was reorganized reducing some non-essential services, in another EMS some of the senior management and staff reduced their work hours and income for several months. By the end of 2021 the financial situation improved for those who were interviewed as bed occupancy also increased, but the measures added to general staff fatigue, especially as this came just after the first year of the pandemic.

DECISION MAKING CLOSE TO THE FIELD: CONTROL, COHERENCE, AND DIVERSITY

Three trends emerge from the interviews around decision making on the pandemic: the authorities took time to consider the specificities of EMS, high uncertainty and risk led to more centralized decision making, and there were different expectations on whether there should be coherence between EMS in the pandemic response.

DELAYS IN CONSIDERING THE SPECIFIC SITUATION OF EMS

Many of the interviewees in Geneva thought that it took the SMC a long time to properly take into account the EMS in the pandemic response. For example, a few mentioned the blind spot on EMS when certain sedatives used for end of life care were no longer available in the market as they were concentrated in the acute hospital services for the first wave. Other interviewees regretted that it took several weeks for the health authorities to provide guidance specific to EMS. For many of the interviewees from the EMS sector this set the tone in the first months that the EMS had to be able to find their own solutions. One of the EMS directors described the frustration with health authorities at the onset of the pandemic:

> "It took them weeks and weeks and weeks to get going. And when we called them, we said I need instructions. I need instructions... And they said "We're meeting on Friday". Except that today was Tuesday and I couldn't wait till Friday of the following week! It's not the right rhythm. And so I said, I'm going to decide for the establishment. I run this place, I manage my risks.... So I made decisions on my own because there was no one to talk to»(Quote 7, Director EMS 8, 08/04/2022)

Another example is that it took authorities at least several months to accept that some infection control measures had to be changed or were not adapted to the EMS context. A common example raised in the interviews was that it wasn't possible to force residents to use masks. Throughout the first year the EMS Task Force and its members played a role in trying to recalibrate some of the measures that could not be applied. At times this meant simply that EMS did not apply the measures.

> "We obeyed the directives, and then we disobeyed them if we saw that they were not humane. But we were right to disobey and afterwards the SMC realised that it was logical. Disobedience means, for example, that we didn't put masks on residents with dementia, that sort of thing. Or not to isolate a resident who doesn't understand what is happening, to isolate them in a room, a resident just wastes away. So, we disobeyed from time to time, that is to say, that we said to ourselves that we didn't want these people to die of sadness, to die of god knows what. And that was understood, but it took a long time, it took a year." (Quote 8, Medical supervisor Dr A, ITV 05/05/2022)

Once the SMC Covid Cell had a team dedicated to EMS clusters, then they were able capitalize on the hands-on experience of EMS. They used it to advice other EMS during an outbreak and nourish discussions in the SMC Covid Cell on the use of restrictions. One of the interviewees from the Covid Cell described weighing the benefits and risks of closing an EMS during an outbreak:

> "It was really debated. Before taking a decision on an EMS in case of an outbreak, the Covid Cell teams had to consult us and each time we weighed the benefits and

> risks and then we would reach an agreement with the EMS managers. Not everything was perfect. Sometimes it was difficult, but we still managed to find the right balance. Even in the cell we debated the issue because it's a big team, there are also internal discussions and some people have a stricter approach. But being strict without taking into account the ground reality can be counterproductive. We also had discussions with people in charge of the EMS who didn't understand, who said 'we have several positive cases, we're closing everything, we don't want any visits'." (Quote 9, Member SMC Covid Cell, 20/05/2022).

THE HIGHER THE SENSE OF RISK AND UNCERTAINTY, THE MORE CENTRALISED CONTROL BY AUTHORITIES.

Most interviewees mention a very strict outlook on nursing homes by the Cantonal covid response at the beginning of the pandemic, with blanket rules prioritizing isolation and protection. This was the moment of most uncertainty and fear of Covid-19. Most of those interviewed understand the decision to close nursing homes to external visits in March 2020 in terms of the fear, risk, uncertainty, and the need to get a better grasp of what was happening. Of the nine EMS directors interviewed in Geneva canton, at least four of them said their EMS closed to visitors 1 to 2 weeks prior to the Geneva Conseil d'Etat decision to stop all visits.

However, several interviewees also mention that for much of the first year there was an excessive expectation to impose restrictions on residents in nursing homes, and this is what raised problems for them:

> "All of a sudden, there was a strong institutional hold on the residents So I found that the authorities, on behalf of Covid, lacked consulting and perspective on the ground reality, residents had to stay in the EMS 24 hours a day from March onwards, so obviously we weren't going to tell them to stay in their rooms, or not to eat together and that they had to wear a mask, that was just inconceivable for us and unthinkable for them". (Quote 10, Director EMS 6, ITV 21/03/2022)

Covid-19 outbreaks were a particularly high risk and uncertain situation, they tended to spread like wildfire in a matter of days, and often required a massive reorganisation. Outbreaks weren't only an issue in nursing homes. One of the doctors from the geriatric ward of HUG described similar Covid-19 outbreaks happening in the hospital:

> "It happened to me twice in my unit. I was told that there were four or five more cases every half day. It's particularly destabilising because you feel like you're doing the right thing, you're taking all the right measures, and then once it spirals out of control, you feel like it's never going to stop." (Quote 11, Dr Y, Geriatric Hospital, HUG 20/06/2022).

Several directors and other interviewees said that in the first year there was a tendency of health authorities to view Covid-19 outbreaks in EMS as a failure of the EMS to follow proper rules that required more controls on what the EMS was doing. One director described managing two nursing homes which are similar in size and with similar teams. Despite following the same protocols and preparation, one EMS had an outbreak and the other didn't, but it wasn't possible to say that one needed more control than the other.

The visit of health inspectors – the GRESI- to several EMS as outbreaks started in the second wave, coupled with public statements from authorities saying that the EMS needed more controls to better follow their protection plans[3] reinforced further the perception amongst EMS that authorities' response focused on control, rather than understanding the ground reality of what was happening.

Once the sense of risk diminished, interviewees described that the authorities were generally more flexible with the recommendations and restrictions.

TENSION BETWEEN A COHERENT RESPONSE AND DIFFERENCES BETWEEN EMS.

Diversity on how EMS adapted protection measures can be attributed to differences of capacity and structure. However, part of the diversity between them is also due to different approaches to care which impact what an EMS prioritizes. For example, one director expressed frustration of not being able to close the EMS to external visitors during the second wave:

> "The law on epidemics was no longer active, and I couldn't close again, it wasn't possible, but it was terrible. We had up to 40 infected residents, whereas the first time there were 13, and we had about twenty deaths. We had about sixty contaminated employees. It was terrible, terrible, terrible. Because we didn't have the possibility of switching on the security system that we had switched on the first time and the institution was open." (Quote 12, Director EMS 8, 08/04/2022)

Some EMS were more prone to stricter control measures to avoid transmission, whereas others were more prone to giving as much space as possible to the residents' social needs and freedom, creating radical differences between the nursing homes. One interviewee from the EMS sector who was in the EMS Covid Task Force expressed regret that there wasn't greater coherence:

> "It was a shame that we [the task force] didn't have some authority because there were EMS that were very closed. They were so closed it was very worrying. It was a complete blackout. And then there were EMS where people could just come in and out. And that for us was a bit difficult." (Quote 13, Member EMS Task Force, 06/04/2022)

This echoes a similar theme outside the pandemic context, on how far the EMS sector should be standardized and to what extent as a private sector most EMS have the freedom to apply different approaches.

[3] Such as Heidi.news, 13th November 2020, https://www.heidi.news/sante-alimentation/une-lueur-d-espoir-et-un-soulagement-la-situation-sanitaire-a-geneve-se-stabilise

DISCUSSION AND CONCLUSION

During the pandemic the EMS in Geneva looked after one of the most dependent and frail people in the country, who were at most risk of developing severe forms of Covid-19. The EMS played an important role in providing care to residents with few referrals made to hospitals and putting in place measures to protect residents.

None of the findings point to a catastrophic lack of resourcing during the pandemic. Globally, nursing homes in Geneva tend to be well resourced, have a high staff to resident ratio, and generally have capacity to provide care compared to nursing homes with a different resident profile or in other countries. But this doesn't mean that the EMS weren't impacted. All the EMS interviewed faced difficulties, particularly when outbreaks or strict protection measures prevented them from providing the levels of care they normally do. They all faced moments of great upheaval, leading to suffering and exhaustion for both residents and staff, and many EMS interviewees describe this as a traumatic experience.

Different organizational characteristics led to a diversity of ways in which EMS were impacted, but a few overarching trends in the environment emerged which influenced the response in EMS.

THE EMS COVID TASK FORCE AS A KEY TOOL FOR SENSEMAKING

First, the EMS Covid Task Force was a key tool for sensemaking at the beginning of the pandemic and became a part of the pandemic environment. It allowed the EMS to benefit from the collective experiences of many EMS in the canton and acted as focal point for health authorities to access the whole EMS sector. It specially helped EMS to deal with the first months of uncertainty on how to adapt protection measures to the EMS context and to provide an initial response to shortages in material.

The EMS Task Force is reminiscent of Karl Weick's 'capacity' for sensemaking in crises. It increased the capacity of EMS and health authorities to understand what was happening in the EMS. It pulled together a variety of professions from the EMS sector, including from the DGS and the EMS federations, and centralised experiences coming from different EMS, allowing for a broad view of what was happening.

For Weick, expectations influence how individuals and organisations understand a crisis as we tend to be more sensitive to cues that best fit our expectations. It's possible that the general position of EMS as being on the periphery of the health network, their tendency to work separately, and the distanced background relation with DGS that many directors described, meant that the lack of initial reactivity towards the EMS by the SMC, reinforced the expectation from EMS that they had to be self-sufficient which is partly what motivated the creation of the EMS Task Force. Not only was it an exercise of sensemaking but it was also exercise of self-sufficiency in the sector.

EXPECTED SELF-SUFFICIENCY OF EMS IN THEIR CORE BUSINESS

The findings suggest that there was a general expectation in the environment, including by many EMS, that nursing homes had to be mainly self-sufficient in their core business. The core business refers to what an EMS normally does which is to provide care to residents, manage human resources and their finances. Tasks outside this are the extra duties brought about by the pandemic: implementing protection protocols, measures to cut transmission, and new tools to help communication between residents and families.

External support focused on the provision of disinfection and protection materials, vaccination and testing, and communications materials such as tablets. These were vital for the EMS, in particular vaccinations were the biggest game changer in the pandemic. However, aside from some financial support given to cover the cost of oxygen bottles, there seems to be no external support for other needs that may have arisen in relation to care provision, such as support if there was a lack of medicines or staff, or just general external support to discuss care protocols and treatment options.

Only limited initiatives existed for care support and these were mainly internal to the EMS sector. The EMS Covid Task Force did field questions about care protocols, and the need to carry out advance health plans for residents, and there was discussion and advice through the medical supervisors who are connected to the Canton's medical networks. However, there was no systemic organizational support for care issues available. The SMC team dedicated to following clusters in EMS focused on managing transmission but there was no other team to support on care during an outbreak. Neither was there a systemic relation with the HUG on issues to do with Covid-19 care, in terms of support or advice. This lack of help for care issues is rarely articulated explicitly as a gap in interviews, as if it just wasn't expected.

According to Weick, a strong commitment on justifications for actions can impact the actor's understanding of a crisis. There was strong public commitment to the reasons for restrictions in the pandemic response: protect the vulnerable, flatten the epidemic curve and preserve the hospital's capacity to treat patients. There was also a strong public commitment to the treatment strategy in Geneva, which was to centralise all Covid-19 hospitalisations in the HUG, which led to a massive reorganisation in the hospital system and the concentration of resources in HUG. In practice though, the EMS also centralised care for Covid-19 patients, as practically all the EMS had outbreaks, and the EMS aimed to keep residents as much as possible to not overload the hospital. But the EMS were not defined as care centres for Covid. The place of EMS in the pandemic response was to protect residents and to avoid an outbreak, which explains why the support provided is mostly on prevention.

It's possible that the commitment to protect the vulnerable, became a general assumption that there would be no large outbreaks in the EMS because their job was to avoid outbreaks. Retrospectively it may seem impossible to avoid widespread outbreaks, but at the time, emphasis was placed on strict measures, with the closure of the EMS in the first wave, when 30% of EMS were impacted. The second wave arrived extremely fast and was much bigger. There was a sense of failure attached to there being so many outbreaks in the EMS, but maybe outbreaks were almost impossible to avoid.

It's also possible that there was an expectation that the EMS had the capacity to provide care during an outbreak, they have after all managed flu and norovirus outbreaks in the

past. As they managed to not refer many residents to hospital, then this could be a sign that they were coping. In this sense, it is just part of their core business which they must know how to manage. However, the virulence of Covid-19 outbreaks took everyone by surprise. In addition the health care capabilities between EMS vary.

It's a telling contrast that the examples of emerging organisations to support nursing homes in other countries tended to focus on establishing links between nursing homes and hospitals to increase support and advice on care issues. In many of these contexts, there isn't a systemic expectation that nursing homes have a high capacity for medical care, the staff resident ratio and financial investments tend to be lower than in Switzerland. In Geneva, this wasn't a role of the EMS Task Force. There is nothing in the interviews, to suggest that there were questions coming from EMS on where they could get support for care issues, or what functional links they could have with the hospital. It simply doesn't seem to be an expectation. It's a very different response compared to the other international studies.

EMS WITH DENSER NETWORKS HAD MORE FACILITY FOR MANAGING SHORTAGES

Thirdly, findings suggest that those EMS who had denser networks or are embedded in more networks prior to the pandemic tended to have more resources or support to manage potential shortages of staff or material. Those EMS who were part of a group of EMS benefitted from the experience and resources of each one compared to those who were alone, based on the interviews carried out. This echoes the findings on interdependencies of nursing homes in the UK, where those nursing homes who were more embedded in their communities were more likely to have support from local organisations.

AMBIGUITY ON THE EMS COLLECTIVE: EMS AS A SECTOR OR AS A PRIVATE ORGANISATION

It is not clear in the pandemic how an issue becomes a sectoral one for EMS, to be followed up by the EMS Task Force or one of the federations and when is it managed as an individual EMS problem in interactions with authorities. The EMS task force emerged as an initiative from the sector, and after about 9 months, according to the interviews, was less mobilized. It's not clear what exactly changed in the EMS Task Force. It reflects broader questions on what triggers the EMS to mobilise as a collective, is it mainly circumstantial, or dependent on other variables. The different expectations that EMS directors have on the federations also translated to the EMS Task Force: some wished for more coherence between EMS in their approach to restrictions, for others, this was a matter of individual organisational responsibility.

DELAYS IN ADDRESSING EMS NEEDS

As seen in other studies, Geneva health authorities were also delayed in addressing the specific situation of EMS, and the set up of the EMS Task Force helped palliate some of this gap for the sector. Once there was a team dedicated to following the situation of EMS in the SMC Covid Cell, then this helped increase the understanding of EMS field realities. This dedicated team was not set up until September 2020 almost 7 months after

the pandemic response started. Before then, there was a high turnover in who followed up with the EMS and no one was fully dedicated to understanding the reality of that context. This points to the need to have a dedicated resource for high risk and complex settings, to better understand their situation.

International studies suggest that the more regulated and embedded nursing homes were in the health system the more rapidly they would be considered in the response. The EMS in Geneva showcase a different set up compared to most of those mentioned in the studies. In Geneva, there is a strong centralised regulation of EMS, a relatively high investment in the sector compared to other countries, and EMS are part of the health system, and not the social system as is the case in the UK for example. However, the EMS in Geneva for the most part seem to have few links with other actors in the health system, including hospitals, and describe themselves as mainly being on the periphery of the health network, with little participation on integrated strategies for the elderly. In this sense they are not strongly embedded within the system in terms of the relations and exchange with other actors, and tend to be either self-reliant or part of other networks they have created. This would suggest, that a lack of embeddedness – despite strong regulation and being part of the health system – is an important variable for nursing homes to be more integrated into response strategies.

CONCLUSION

This study aimed to understand how the environment framed the pandemic response for nursing homes in Geneva. The pandemic brought care issues linked to protection measures to the centre of interactions between nursing homes and their environment: how to reconcile protection from the virus with the residents' well-being, and when to prioritize one over the other. At the same time there was little organisational support available to nursing homes for care provision, as most support focused on prevention measures. This is partly because there is a high expectation that EMS are mostly private self-sufficient entities who have the means to provide care. In all cases, the findings underline the need to rapidly integrate the experience of frontline practitioners in decisions on the response, be it at EMS level (the proximity of managers with frontline staff, families and residents) and at interorganisational level with authorities and the EMS Task Force.

This exceptional crisis put the spotlight on how detrimental social restrictions can be for the health and wellbeing of elderly people in long-term care facilities. It remains to be seen how this can be used to draw lessons on care provision today, and how it can feed into discussion on the role of EMS and on broader debates around care for the elderly.

BIBLIOGRAPHY

Bernabeu-Wittel M, Ternero-Vega JE, Nieto-Martín MD, Moreno-Gaviño L, Conde-Guzmán C, Delgado-Cuesta J, Rincón-Gómez M, Díaz-Jiménez P, Giménez-Miranda L, Lomas-Cabezas JM, Muñoz-García MM, Calzón-Fernández S and Ollero-Baturone M (2021), Effectiveness of a On-site Medicalization Program for Nursing Homes With COVID-19 Outbreaks, *The Journals of Gerontology: Series A*, 76(3), pp. e19–e27.

Bertrand C, Laurent M and Lecarpentier E (2020), Aide médicale urgente — établissement d'hébergement des personnes âgées dépendantes : retour d'expérience d'une organisation innovante pendant la crise Covid-19, *Annales françaises de médecine d'urgence*, 10(4–5), pp. 218–223.

Comas-Herrera A, Marczak J, Lorenz-Dant K, Patel D, Pharoeh D and LTC Contributors (2022), *LTCcovid International living report on COVID-19 and Long-Term Care*, LTCCovid and Care Policy and Evaluation Centre, LSE., [en ligne], https://ltccovid.org/questions/2-00/2-02/, (accessed 20 July 2022), mimeo.

Conseil d'Etat (2020), *Rapport de gestion 2020*, Genève: Conseil d'Etat, Canton de Genève, [en ligne], https://www.ge.ch/document/24286/telecharger, (accessed 7 June 2022), mimeo.

Conseil d'Etat (2021), *Rapport de gestion 2021*, Genève: Conseil d'Etat, Canton de Genève, [en ligne], https://www.ge.ch/document/28145/telecharger, mimeo.

Coulongeat Matthieu, Aïdoud Amal, Poupin Pierre, Dubnitskiy-Robin Sophie and Fougère Bertrand (2021), A Local COVID-19 Support Platform for Nursing Homes: Feedback and Perspectives, *Journal of the American Medical Directors Association*, 22(8), pp. 1599–1601.

Curt Laure (2019), *Analyse transversale données PLAISIR Octobre 2019*, Commission technique intercantonale PLAISIR, pp. 69, [en ligne], http://www.ctplaisir.ch/tttdonnees_2019_10.pdf, mimeo.

Curt Laure (2020), *Rapport Annuel Plaisir 2020*, Rapport annuel, Commission technique intercantonale PLAISIR, pp. 30, [en ligne], http://www.ctplaisir.ch/ct-rapports.html, mimeo.

Daly Mary (2020), COVID-19 and care homes in England: What happened and why?, *Social Policy & Administration*, 54(7), pp. 985–998.

Daly Mary, León Margarita, Pfau-Effinger Birgit, Ranci Costanzo and Rostgaard Tine (2022), COVID-19 and policies for care homes in the first wave of the pandemic in European welfare states: Too little, too late?, *Journal of European Social Policy*, SAGE Publications Ltd, 32(1), pp. 48–59.

de Rivero Kate (2022), Pris par la vague: les EMS en première ligne face au Covid-19 (Ch 8), In: , *Inventer le quotidien au temps du Covid-19: communiquer, soigner et organiser*, Sociograph, Université de Genève, pp. 265, [en ligne], https://www.unige.ch/sciences-societe/socio/fr/publications/dernierespublications/sociograph-55-sociological-research-studies/.

DSPS (2020), Communiqué: la stratégie suisse pour répondre à l'épidémie de COVID-19, Département de la sécurité, de la population et de la santé (DSPS), [en ligne], https://www.ge.ch/node/19931.

Estabrooks Carole A, Straus Sharon E, Flood Colleen M, Keefe Janice, Armstrong Pat, Donner Gail J, Boscart Véronique, Ducharme Francine, Silvius James L and Wolfson Michael C (2020), Restoring trust: COVID-19 and the future of long-term care in Canada, Blais Jules M (Ed.), *FACETS*, 5(1), pp. 651–691.

Fegems (2020), *Rapport d'activité 2020*, Geneva: Fédération genevoise des établissements médico-sociaux, [en ligne], https://www.fegems.ch/, mimeo.

Fegems (2021), Communiqué de presse: -EMS en difficulté : la Fegems tire la sonnette d'alarme, [en ligne], https://www.fegems.ch/wp-content/uploads/2021_CP-EMS-en-diffculte-20210205.pdf, (accessed 5 May 2022).

Fowler-Davis Sally, Cholerton Rachel, Philbin Mandy, Clark Kathy and Hunt Gill (2021), Impact of the Enhanced Universal Support Offer to Care Homes during COVID-19 in the UK: Evaluation using appreciative inquiry, *Health & Social Care in the Community*, n/a(n/a), [en ligne], https://onlinelibrary.wiley.com/doi/abs/10.1111/hsc.13612.

Freidus Andrea, Shenk Dena, Davies Megan, Wolf Christin and Staudacher Sandra (2022), Long-Term Care Staff Perceptions of Providing Care During the COVID-19 Pandemic in the United States and Switzerland: Balancing Protection and Social Isolation, In: Vindrola-Padros Cecilia and Johnson Ginger A (Eds.), *Caring on the Frontline during COVID-19*, Singapore: Springer Singapore, pp. 159–178, [en ligne], https://link.springer.com/10.1007/978-981-16-6486-1_8, (accessed 18 July 2022).

Fries Sabine, Trageser Judith, Ehmann Beatrice and Mäder Alexandra (2021), *Graphiques des résultats de l'enquête auprès des directions d'institutions*, INFRAS sur mandat de l'Office fédéral de la santé publique (OFSP), pp. 96, mimeo.

Grand Conseil République et canton de Genève (2008), *Loi sur le réseau de soins et le maintien à domicile LSDom - K 1 06 (Entrée en vigueur 1/2/2010)*, [en ligne], https://www.lexfind.ch/tolv/179674/fr.

Grand Conseil République et canton de Genève (2009), *Loi sur la gestion des établissements pour personnes âgées LGEPA - J 7 20 (Entrée en vigueur 01/04/2010)*, [en ligne], https://www.lexfind.ch/tolv/199840/fr.

Grand Conseil République et canton de Genève (2016), *Loi sur le repartition des taches entre les communes et le canton LRT-1 A 2 05 ((Entrée en vigueur 01/01/2017)*.

Huber A and Seifert A (2022), Retrospective feelings of loneliness during the COVID-19 pandemic among residents of long-term care facilities, *Aging and Health Research*, 2(1), pp. 100053.

Inzitari Marco, Risco E, Cesari M, Buurman BM, Kuluski K, Davey V, Bennett L, Varela J and Prvu Bettger J (2020), Nursing Homes and Long Term Care After COVID-19: A New ERA?, *The journal of nutrition, health & aging*, 24(10), pp. 1042–1046.

Ionita Irina (2019), *Pour une vision politique globale des seniors à Genève*, Genève: late-forme des associations d'aînés à Genève, [en ligne], https://www.plateformeseniors.ch/wp-content/uploads/2020/08/rapport-plateforme-2019-version-finale.pdf, mimeo.

León Margarita, Arlotti Marco, Palomera David and Ranci Costanzo (2021), Trapped in a Blind Spot: The Covid-19 Crisis in Nursing Homes in Italy and Spain, *Social Policy and Society*, pp. 1–20.

Marshall Fiona, Gordon Adam, Gladman John RF and Bishop Simon (2021), Care homes, their communities, and resilience in the face of the COVID-19 pandemic: interim findings from a qualitative study, *BMC Geriatrics*, 21(1), pp. 102.

McGarry Brian E and Grabowski David C (2021), Nursing Homes and COVID-19: A Crisis on Top of a Crisis, *The ANNALS of the American Academy of Political and Social Science*, SAGE Publications Inc, 698(1), pp. 137–162.

OCSTAT Office cantonal de la statistique (2022), Système de santé, *Statistiques cantonales - Canton de Genève*, [en ligne], https://statistique.ge.ch/domaines/apercu.asp?dom=14_02, (accessed 3 March 2022).

OECD (2020), *Spending on long-term care*, [en ligne], https://www.oecd.org/health/health-systems/Spending-on-long-term-care-Brief-November-2020.pdf, mimeo.

OECD (2021), *Rising from the COVID 19 crisis: Policy responses in the long-term care sector*, OECD Policy Responses to Coronavirus (COVID-19), OECD Policy Responses to Coronavirus (COVID-19), [en ligne], https://www.oecd-ilibrary.org/social-issues-migration-health/rising-from-the-covid-19-crisis-policy-responses-in-the-long-term-care-sector_34d9e049-en, mimeo.

OECD (2022), OECD Statistics - Health / Long-Term Care Resources and Utilisation, *OECD.Stat*, [en ligne], https://stats.oecd.org/, (accessed 1 July 2022).

OFS Office fédéral de la statistique (2020), Statistique des institutions médico-sociales 2019 - Tableaux standard - 2019 | Tableau, *Office fédéral de la statistique*, [en ligne], https://www.bfs.admin.ch/asset/fr/14840497, (accessed 4 July 2022).

OFS Office fédéral de la statistique (2021), *Impact de la pandémie de Covid-19 sur les services de santé en 2020*, Neuchâtel: OFS - Office fédéral de la statistique, [en ligne], https://www.bfs.admin.ch/bfs/fr/home/actualites/quoi-de-neuf.assetdetail.20444122.html, mimeo.

OFS Office fédéral de la statistique (2022), Statistique des institutions médico-sociales 2020 - Tableaux standard - 2020 | Tableau, *Office fédéral de la statistique*, [en ligne], https://www.bfs.admin.ch/asset/fr/21324449, (accessed 3 July 2022).

OFSP Office Fédéral de la Santé Publique (2021), *Décès liés au COVID-19 en Suisse et en comparaison internationale - données février 2021*, Bern: Département fédéral de l'intérieur, Confédération Suisse, [en ligne], https://www.bag.admin.ch/bag/fr/home/krankheiten/ausbrueche-epidemien-pandemien/aktuelle-ausbrueche-epidemien/novel-cov/situation-schweiz-und-international.html, mimeo.

Prieur Marie (2020), Près de 180 lits disponibles dans les EMS genevois, *GHI*, 21st December, [en ligne], https://www.ghi.ch/le-journal/geneve/pres-de-180-lits-disponibles-dans-les-ems-genevois, (accessed 13 April 2022).

Secrétariat du Grand Conseil (2019), *Rapport de la Commission des finances PL12234A*, Genève, [en ligne], https://ge.ch/grandconseil/data/texte/PL12234A.pdf, mimeo.

SMC (Service du Médecin Cantonal) (2021), *Covid-19 Point Epidémiologique Hebodamadaire Canton de Genève Semaine 10*, Genève: Département de la sécurité, de l'emploi et de la santé (DSES) Direction générale de la santé, [en ligne], https://www.ge.ch/document/19696/annexe/6, (accessed 18 May 2021), mimeo.

Swiss National Covid-19 Science Task Force (2020), *Continued confinement of those most vulnerable to COVID19*, ELSI report, [en ligne], https://sciencetaskforce.ch/en/policy-brief/continued-confinement-of-those-most-vulnerable-to-covid-19-2/, (accessed 7 May 2022), mimeo.

Trageser Judith, Weber Romina and Ehmann Beatrice (2021), *Graphiques des résultats de l'enquête auprès des proches - Situation des personnes âgées et des personnes résidant dans des établissements médi-*

co-sociaux et des institutions d'encadrement, INFRAS sur mandat de l'Office fédéral de la santé publique (OFSP), pp. 70, mimeo.

von Stokar Thomas, Vettori Anna, Fries Sabine, Trageser Judith and von Dach Andrea (2021), *Crise du coronavirus : analyse de la situation des personnes âgées et des personnes résidant dans des institutions sociales (Executive summary)*, INFRAS sur mandat de l'Office fédéral de la santé publique (OFSP), [en ligne], https://www.aramis.admin.ch/Default?DocumentID=67919&Load=true, (accessed 1 February 2022), mimeo.

Weick Karl E (1988), Enacted Sensemaking in Crisis Situations, *Journal of Management Studies*, 25(4), pp. 305–317.

Weick Karl E (1995), *Sensemaking in organizations*, Sage.

Weick Karl E and Sutcliffe Kathleen M (2015), Managing the Unexpected - Sustained Performance in a Complex World (3rd Edition), John Wiley & Sons, [en ligne], https://app.knovel.com/hotlink/toc/id:kpMUSPCWE1/managing-unexpected-sustained/managing-unexpected-sustained.

ANNEXES

ANNEX 1 - STRUCTURE OF INTERVIEWS

After the general presentation of the research and clarifications on consent or any other questions the interviews were structured around four main areas:

1) A general description of the EMS. If not an EMS, then of their organisation, their role in their organisation and links with EMS.

2) The main stages of the pandemic in chronological order (first wave, second wave, vaccination roll out and after), their priorities, their main challenges and what helped in each phase.

a. For EMS in case these topics hadn't come up I asked about access to material, access to human resources, tests, financial impact of the pandemic, anticipatory directives.

b. For EMS in case these actors hadn't come up I asked about links in the health network, with the health authorities, the hospital, other associations, the EMS Task Force, families, and any other external actors they thought important but hadn't mentioned so far.

c. For non-EMS: I asked about evolving links with EMS and themes that were relevant to their area of work that had come through in the EMS interviews.

3) EMS networks prior to the pandemic and their place/links in the social and health system of the canton.

4) Lessons learned or recommendations about EMS in the pandemic

ANNEX 2 - TABLE OF ORGANISATIONAL VARIABLES AND AREAS OF CONCERN / UNCERTAINTY

	AREAS OF CONCERN TO MITIGATE UNCERTAINTIES	
	Care provision and protection	**Access to resources**
Potential uncertainties linked to the pandemic	Lack of knowledge on the virus and disease, on protocols, on how long pandemic will last, on what reorganisation is necessary to follow recommendations, on impact for residents and staff, on how to reconcile quality of care with protection measures	Shortages of material, medicine and staffing in different phases of the pandemic
ORGANISATIONAL VARIABLES	Impact	Impact
Structure EMS that are part of an EMS group under same management	EMS that are part of a group learn from the first Covid-19 outbreak in one EMS (care protocols) which then helps when there are outbreaks in the others in terms of gaining experience and protocols	EMS that are part of a group are able to share material and oxygen between them if they don't have outbreaks at the same time (none of those interviewed had simultaneous outbreaks)
Size and architecture	Size and architecture impacts whether it is possible to isolate different areas to limit contamination if there is an infection, have a dedicated ward for residents with Covid-19, determines circuits for residents and staff to avoid cross contamination, for example, whether there is one elevator or several elevators, and how to organize family visits.	Small structures said they were not prioritized by suppliers in the first wave. Large amounts in contracts with a supplier favours securing resources.
other	Residents with advanced dementia walk around and can't wear masks, so Covid-19 was likely to spread rapidly if it entered / Residents with advanced dementia didn't mind sleeping in different rooms allowing to reorganise areas for residents with Covid-19, where they could walk around	EMS attached to a hospital (outside Geneva) always had supplies from hospital and access to tests
Capacities	In Wave 1 shortages of sedatives in the market as they concentrated in the HUG for acute care, EMS with low supplies and a Covid-19 outbreak in the first wave are negatively impacted in care delivery. Lack of protective material leads to reusing masks and/ or gowns. Tests with rapid results improves care, need to isolate residents as little as possible, those who stay in isolation for long suffer too much, so big impact on the quality of life the person. In some EMS medical supervisor is not very involved, even absent in a few reported cases, this impacts the support for nursing teams, for staff in general, care capacity, and weakens link between the EMS with the medical community In some EMS, the treatment doctors do not come during the first wave, or come less during the pandemic, so follow up of residents must be done by medical supervisor increasing work load. Human resources: Some EMS have difficulty finding replacement of staff during Wave 2 outbreak, increased work hours for teams, constant reorganisation and stretched teams leads to prioritizing care activities, EMS impacted by financial difficulties also reduces staff capacity (such as : delay replacing vacant positions) adding to exhaustion, and reorganising care activities.	EMS who had large stocks of material before the pandemic or who ordered supplies very early on were likely to avoid shortages in Wave 1 ex. one EMS had ordered masks before the pandemic as part of their flu preparation. EMS who had dense supply networks or strong links with private sector were more likely to find solutions such as those with long term contracts with staff agencies and suppliers EMS with large financial reserves were not affected by the financial impact of having empty beds after wave 2. Some EMS did not depend on temporary staffing agencies, and used their own network they developed for staff replacements Some EMS organise teams to sew their own masks in Wave 1 or gown in Wave 2 to avoid shortages
Philosophy or approach	Diversity in approaches to care and to risk - some EMS more 'risk averse' want to close quickly when there are cases and be more restrictive with activities inside, others want to keep it as open as possible, impacts care provision.	EMS who do not use external service providers or temporary staff agencies because they want to create a 'family atmosphere' so have their own networks to replace staff / didn't compete with other health actors seeking staff Some EMS train all staff to be able to provide assis-

		tance to residents in case of staff infections - so teams are mixed and roles shared, other EMS keep role separate, due to different vision on management.

	Decision making
Potential uncertainties linked to the pandemic	Information changes constantly the first months, uncertainty if recommendations and measures are not adapted to the EMS, rapidity of pandemic in the first waves means teams learn by doing and constantly adapting
ORGANISATIONAL VARIABLES	
Structure EMS that are part of an EMS group under same management	Experience in one EMS can inform decision making in another if they are similar in size / architecture / population
Size and architecture	Large structure with many beds has increased risk exposure, and tends to lead to stricter decisions
other	EMS who have daily partnership with other organisations had to reconcile Covid measures for both institutions. For example, one EMS provides school lunch for 180 children in the EMS building, needed to adapt decisions to be able to continue providing lunches.
Capacities	Proximity of management team with staff allowed to take decisions that were relevant to what was happening Different experience and background of directors impacts decision making and approach Personal links / networks with authorities helps with discussion on Covid-19 measures
Philosophy or approach	EMS attached to the canton wanted to have a coherent policy and applied regulations strictly (according to one ITV with an EMS)

ANNEX 3 - QUOTES IN FRENCH AND ENGLISH

The original version of the quotes are placed next to the translation.

Original in French	Translation
« Finalement un placement dans un EMS, c'est perçu comme un échec de la politique de la personne âgée, au lieu d'être vue comme quelque chose dans la continuité d'une bonne politique de la personne âgée. Il y a des gens qui peuvent rester à domicile et c'est très bien. Il y a des gens qui ne sont plus confortables chez eux, pas uniquement pour des questions de santé, mais ce sont des questions d'isolement, de manque de lien. » (Quote 1, Directeur EMS 1, ITV 03/04/2022)	"In the end, the arrival of someone in an EMS is seen as a failure of policy for the elderly, instead of being seen as a continuation of a good policy for the elderly. There are people who can stay at home and that's fine. But there are people who are no longer comfortable in their own homes, not only for health reasons, but because of isolation and lack of contact" (Quote 1, Director EMS 1, 03/04/2022.)
« Je me suis dit mais il faut qu'on coordonne tout ça parce que ça va être juste très difficile si chaque EMS, on doit gérer chacun la pandémie. Si on attend trop longtemps, ça va être le service du médecin cantonal qui ne connaît pas les EMS, qui va nous donner des règles, qui va nous donner des directives, des normes qui ne seront simplement pas applicables. » (Quote 2, Director EMS 9, 23/06/2022.)	"I told myself that we had to coordinate all of this because it was going to be extremely difficult if each EMS, had to deal with the pandemic on its own. If we waited too long, it would be the cantonal medical service, that doesn't know EMS who will put down rules and directives, that simply would not be applicable" (Quote 2, Director EMS 9, 23/06/2022.)
"C'est le seul moment dans ma position où j'ai vu un rapprochement entre les différentes associations et puis avec l'Etat. Souvent quand on est en contact avec l'Etat, c'est soit qu'ils ont pondu un nouveau règlement, qu'il faut qu'on mette en application, soit qu'on a une plainte à leur refaire remonter. Là, on a vraiment travaillé ensemble. » (Quote 3, Member EMS Task Force, 18/05/2022.)	"It is the only time when I've seen all the different associations get closer to each other and with the State. Often, when we are in touch with the state, it is either be-cause they have new rules, that we must apply, or because we have a complaint to es-calate. But here, we really worked together." (Quote 3, Member EMS Task Force, 18/05/2022.)
« On avançait dans le savoir au fur et à mesure qu'on avançait dans la crise. Donc tous les jours, on avait des nouveaux trucs qui apparaissaient. Il y avait des fois des temps de latence au niveau de l'État pour donner des directives. Ils avançaient comme nous quoi." (Quote 4, Member EMS Task Force, 18/05/2022.)	"We were learning as we went along in the crisis. Every day, we faced new situations which appeared. Sometimes there was a delay at the State level to give new recommendations. They were moving along like us". (Quote 4, Member EMS Task Force, 18/05/2022.)
« On s'est vraiment aperçu au quotidien que les EMS gardaient leurs patients et les géraient sur place tant qu'ils pouvaient, tant que la situation du patient le permettait, ou même ont mis en place des soins palliatifs quand c'était nécessaire. Donc vraiment, cela a été extrêmement clair sur toutes	"We noticed on a daily basis that the EMS kept their patients and managed them on site as long as they could, as long as the patient's situation allowed it, they even set up palliative care when it was necessary. It was extremely clear that in all

les vagues qu'on avait finalement peu de patients qui venaient - tout étant relatif - qui venaient d'EMS et les patients qui étaient hospitalisés venaient beaucoup plus du domicile. Ça, c'était très clair et ils ont vraiment joué le jeu pour garder les patients le plus longtemps possible sur leur lieu de vie habituel. Cela a été très flagrant pour nous. » (Quote 5 Dr Y, Geriatric Hospital, HUG 20/06/2022)	the waves we had few patients coming - everything being relative - but few patients coming from the EMS, and the patients who were hospitalised came mainly from private homes. That was very clear and they really played the game to keep the patients as long as possible in their usual place of residence. That was evident to us. (Quote 5, Dr Y, Geriatric Hospital, HUG 20/06/2022)
"Et on s'est vite rendu compte que les facteurs limitants c'était la disponibilité en personnel et en oxygène dans les EMS. Si je n'ai pas le personnel pour garder la nuit et si je n'ai pas l'oxygène, vous transférez, parce que c'est l'hôpital qui a de l'oxygène à profusion et qui a rassemblé tous les soignants. Donc c'était aussi simple que ça. C'était oxygène et personnel. » (Quote 6 Medical supervisor Dr A, ITV 05/05/2022)	"We quickly realised that the limiting factors were the availability of staff and oxygen in the EMS. If I don't have the staff to stay overnight and if I don't have the oxygen, then we need to transfer, because it's the hospital that has plenty of oxygen and that has gathered all the staff. So it was as simple as that: was oxygen and staff . (Quote 6 Medical supervisor Dr A, ITV 05/05/2022)
" Il leur a fallu des semaines et des semaines et des semaines pour se mettre en route. Et quand on les appelait, on disait mais là, j'ai besoin de consignes. Il me faut des consignes…"Oui, mais alors on va se réunir vendredi". Sauf qu'aujourd'hui on est mardi. Je ne vais pas attendre vendredi de la semaine prochaine ! Ce n'est pas le bon tempo. Et du coup, moi j'ai dit mais je vais décider pour l'établissement. Je dirige l'établissement, je gère mes risques…. Donc j'ai pris des décisions toute seule parce qu'en face il n'y avait pas d'interlocuteur » "(Quote 7 Director EMS 8, 08/04/2022)	"It took them weeks and weeks and weeks to get going. And when we called them, we said I need instructions. I need instructions... And they said "We're meeting on Friday". Except that today was Tuesday and I couldn't wait till Friday of the following week! It's not the right rhythm. And so I said, I'm going to decide for the establishment. I run this place, I manage my risks.... So I made decisions on my own because there was no one to talk to"(Quote 7, Director EMS 8, 08/04/2022)
"On a obéi aux directives et ensuite on a désobéi quand on a vu que ce n'était pas humain. Mais on a bien fait de désobéir parce qu'après le service du médecin cantonal s'est rendu compte que c'était logique. Désobéir veut dire, par exemple, qu'on n'a pas mis des masques aux patients déments qui ont des troubles du comportement, ce genre de choses. Ou alors, d'isoler un résident démens qui ne comprend rien du tout, de l'isoler dans une chambre, alors il se laisse aller. Il y a le fameux syndrome de glissement. Donc là, on a aussi de temps en temps désobéi, c'est à dire qu'on s'est dit mais on ne veut pas que ces gens meurent de tristesse, meurent de Dieu sait quoi donc. Et ça, ça a été compris, mais tardivement, ça a pris un an. » (Quote 8, Medical supervisor Dr A, ITV 05/05/2022)	"We obeyed the directives, and then we disobeyed them if we saw that they were not humane. But we were right to disobey and afterwards the SMC realised that it was logical. Disobedience means, for example, that we didn't put masks on residents with dementia, that sort of thing. Or not to isolate a resident who doesn't understand what is happening, to isolate them in a room, a resident just wastes away. So, we disobeyed from time to time, that is to say, that we said to ourselves that we didn't want these people to die of sadness, to die of god knows what. And that was understood, but it took a long time, it took a year." (Quote 8, Medical supervisor Dr A, ITV 05/05/2022)
« Ça a été très débattu. Et nous, avant de prendre une décision sur un EMS en cas de flambées, les équipes [de la cellule] devaient nous consulter et à chaque fois on pesait les bénéfice-risques et on s'accordait avec les responsables du EMS. Tout n'a pas été parfait. Parfois, ça a été difficile, mais	"It was really debated. Before taking a decision on an EMS in case of an outbreak, the Covid Cell teams had to consult us and each time we weighed the benefits and risks and then we would reach an agreement with the EMS managers. Not everything was perfect. Sometimes it was difficult, but we still managed to find the

on arrivait quand même à trouver le juste milieu. Même à la cellule, il y avait cette démarche parce que c'est une grosse équipe, il y a des discussions aussi en interne et certaines personnes sont plus stricts. Mais quand vous êtes stricts et vous ne tenez pas compte de la réalité, c'est contre-productif. On a eu des discussions aussi avec des responsables des EMS qui ne comprenaient pas, qui disaient 'on a plusieurs cas positifs nous on ferme tout, on ne veut pas de visites, on ne veut pas.' » (Quote 9, Member SMC Covid Cell, 20/05/2022)	right balance. Even in the cell we debated the issue because it's a big team, there are also internal discussions and some people have a stricter approach. But being strict without taking into account the ground reality can be counterproductive. We also had discussions with people in charge of the EMS who didn't understand, who said 'we have several positive cases, we're closing everything, we don't want any visits'." (Quote 9, Member SMC Covid Cell, 20/05/2022).
"Tout d'un à coup, il y avait une mainmise institutionnelle sur eux [les résidents] qui est assez forte. Donc ça, j'ai trouvé que de la part des autorités, au nom du Covid, ça manquait de concertation et de prise de recul par rapport à la réalité du terrain. Et si ces gens n'avaient plus qu'à rester 24 h sur 24 enfermés dès le mois de mars, donc, bien évidemment, qu'on n'allait pas encore leur dire restez dans vos chambres, ne mangez plus ensemble et portez le masque, c'était juste pour nous inconcevable et pour eux, impensable. » (Quote 10 Director EMS 6, ITV 21/03/2022)	"All of a sudden, there was a strong institutional hold on the residents So I found that the authorities, on behalf of Covid, lacked consulting and perspective on the ground reality, residents had to stay in the EMS 24 hours a day from March onwards, so obviously we weren't going to tell them to stay in their rooms, or not to eat together and that they had to wear a mask, that was just inconceivable for us and unthinkable for them". (Quote 10 Director EMS 6, ITV 21/03/2022)
« Il est arrivé dans mon unité, à deux reprises, qu'on m'annonce quatre ou cinq cas supplémentaires, toutes les demi-journées. C'est particulièrement déstabilisant parce qu'on a l'impression de faire ce qu'il faut, de faire les bons gestes, et puis, une fois que l'engrenage est parti, on a l'impression que ça ne s'arrêtera jamais.» (Quote 11, Dr Y, Geriatric Hospital, HUG 20/06/2022).	"It happened to me twice in my unit. I was told that there were four or five more cases, every half day. It's particularly destabilising because you feel like you're doing the right thing, you're taking all the right measures, and then once it spirals out of control, you feel like it's never going to stop." (Quote 11, Dr Y, Geriatric Hospital, HUG 20/06/2022).
«La loi sur les épidémies n'était plus active, et je ne pouvais pas refermer, ça n'était pas possible et donc ça a été terrible. On a eu au niveau des résidents jusqu'à 40 personnes contaminées alors que la première fois il y en avait 13, on a eu une vingtaine de décès. On a eu une soixantaine de collaborateurs contaminés. Ça a été terrible, terrible, terrible. Parce qu'on n'avait pas la possibilité d'enclencher la sécurité qu'on avait enclenché le premier tour et que l'établissement était ouvert. » (Quote 12 Director EMS 8, 08/04/2022)	"The law on epidemics was no longer active, and I couldn't close again, it wasn't possible, but it was terrible. We had up to 40 infected residents, whereas the first time there were 13, and we had about twenty deaths. We had about sixty contaminated employees. It was terrible, terrible, terrible. Because we didn't have the possibility of switching on the security system that we had switched on the first time and the institution was open." (Quote 12 Director EMS 8, 08/04/2022)
« Peut-être que c'était dommage qu'on [the task force] n'ait pas une certaine autorité parce qu'il y a des établissements qui étaient très fermés. Vous voyez très fermé, qui était très inquiétant. C'était black out complet. Et il y a eu des établissements, ou les entrées et sorties étaient fluides. Vous voyez ça, c'était pour nous, c'était un peu difficile. » (Quote 13. Member EMS Task Force, 06/04/2022)	"It was a shame that we [the task force] didn't have some authority because there were EMS that were very closed. They were so closed it was very worrying. It was a complete blackout. And then there were EMS where people could just come in and out. And that for us was a bit difficult." (Quote 13, Member EMS Task Force, 06/04/2022)