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Uncovering the Devaluation of Nursing Home Staff During COVID-19: Are We Fuelling the Next Health Care Crisis? JAMDA Editorial (2020 May accepted; in press)

Uncovering the Devaluation of Nursing Home Staff During COVID-19: Are We Fuelling the Next Health Care Crisis?

As the COVID-19-related mortality rate of nursing home residents continues to rise, so too will the rates of mortality and morbidity of staff who care for them,[1] a problem we must address now to avoid another health care crisis once this pandemic recedes. Currently, a significant proportion of deaths are attributed to persons living in nursing homes, ranging from 42-57% in European countries reporting data[2] to as high as 82% in several U.S. states and in Canada reporting data.[2, 3] However, there is a concern that many countries are not including nursing home deaths in the death toll. While not reported globally experts predict, the majority of health care workers who will die from COVID-19 are nursing staff (nurses and nursing assistants) working in nursing homes.[1]

Most residents in nursing homes are over the age of 80 and have multiple chronic conditions and are at risk of COVID-19. However, several factors unrelated to the residents themselves increase their vulnerability to COVID-19 as well as members of nursing home staff. The pandemic has laid bare long-standing structural deficiencies affecting the nursing home sector. Chronic understaffing in nursing homes is a global concern, which makes providing basic care a challenge, and has made monitoring residents for COVID-19 symptoms even more difficult.[4] Understaffing also undermines a staff's ability to follow protocols to keep residents physically distant, as public health measures to reduce the transmission of the virus including isolating residents when COVID-19 positive can exacerbate behaviors in residents with dementia who may not understand or follow the procedures.[5] Staffing levels in nursing homes continue to be a concern globally.[6] Precarious work conditions characterized by part-time employment, heavy workloads, punitive measures related to sick time, low wages and an obligation to work when sick[7] contribute to a global staffing crisis in nursing homes. Family members and other volunteers have frequently provided supportive care in the past, but with the visitors ban due to COVID-19, this support has vanished, further exposing the vulnerabilities and consequences associated with chronic staffing shortages. Nursing homes are working under capacity, as staff have tested positive for COVID-19 symptoms.[1] At the same time, some countries report significant rates of staff absenteeism or abandonment of their work due to fear of getting the virus or transmitting it to their loved ones.[8, 9] This fear is not unfounded, as many staff providing the most hands-on, direct care in nursing homes (e.g., bathing, assisting with meals, etc), are women, who have double or triple caregiving responsibilities[7], with a low socio-economic status that cannot risk income loss regardless of working conditions, and are at high risk for poor health outcomes if infected. Also, it is known that staff are most likely spreading the virus within nursing homes[10] especially because many who are subject to low wages and the part-time employment culture are forced to work at multiple nursing homes in order to earn a livable wage. The expected grief, guilt and moral distress of losing residents they have cared for over many years, the moral injury related to working under high pressure and possibly violating their own

ethical or moral codes[11]–coupled with the potential guilt of their own role in transmission – will need to be addressed.

The COVID-19 pandemic has also revealed and accentuated the ageism and devaluing of older people pervasive in many societies.[12] By association, the nursing home staff workforce also experiences devaluing, a long-standing reality which has become more apparent as the pandemic expands globally. The public campaign 'clap for medical staff' worldwide[13] and 'clap for those in the National Health Service' in the UK[14] initially appeared to ignore staff in nursing homes. Shortly after, the slogan was changed in many countries to 'clap for carers or health care workers.' While anecdotal, the initial messaging implies that nursing home staff are often an afterthought, frequently ignored in health care system conversations.

One of the most blatant signs of devaluing older people in nursing homes and their workforce is society's failure to keep nursing home residents and their staff safe. Most of the initial government COVID-19 guidelines took a hospital-centric approach and focused largely on nursing homes as venues for discharge. While our acute care hospitals were encouraged and enabled by their governments to gear up and order supplies for their staff, where was the pandemic planning and supplies for nursing home staff? Unprecedented times call for unprecedented measures for everyone. Eventually official documents that provided specific guidance about how to manage pandemics in nursing homes emerged in several countries, but it is unclear how this information was transferred to the numerous nursing homes and what supports were being provided to facilitate the uptake of this new information within individual nursing homes. As an acknowledgement to the care sector for their contribution, the Secretary of State for Health and Social Care in the UK launched an initiative consisting of a 'CARE' badge, which was met with backlash from nursing home workers, the workers declaring, 'don't give us a badge, give us PPE'.[15] Their sentiment was echoed by staff in the United States[16] and confirmed by accounts reporting that 70% of nursing home providers were unable to find sufficient supplies for their staff.[17] Whilst the delays associated with PPE provision in nursing homes partly reflect the logistical challenges of getting equipment to a large number of dispersed facilities, the failure to prioritise such planning earlier has served to further marginalise this important group of healthcare professionals, at a time when they need more support and recognition than ever. Two months into the pandemic, many staff in nursing homes globally continued to work without PPE[16] and the serial changes to guidelines had left them confused about what equipment to use and when. While the pandemic brings extraordinary challenges to healthcare settings across the continuum, the disproportionate risk of COVID-19 spreading in nursing homes demands greater attention, to protect our most vulnerable populations and the staff that provides their care.

We, as a global society, have failed our nursing home community, residents, relatives and staff. Given that this pandemic has publicly revealed and aggravated the long-standing age-old precarious working conditions in nursing homes, it can be reasonably expected that future recruitment of staff will be an even greater challenge in the future. The current crisis highlights the ingrained poor status of a workforce that is taken for granted and ignored, despite supporting the health and well-being of some of the most vulnerable older adults in society.

As concerned advocates and researchers, it is our opinion that we need to better protect and support the frail older adults residing in nursing homes, their relatives and the workforce (staff

and leadership) that provide care in these settings. Relatives in lockdown not only need to be protected from the infection, but also the grief of being isolated from their family members. We represent members of a global consortium of long-term care (LTC) researchers, the Worldwide Elements To Harmonize Research In long-term care liVing Environments (WE-THRIVE). Our overarching goal is to collaboratively advance an international LTC research measurement infrastructure that can be used efficiently in diverse, residential LTC settings for comparative research to advance resilience and thriving among residents, staff, and family members including persons in low and middle income countries.[18] The pandemic has highlighted a lack of data across our respective countries in comprehensively understanding why some homes have managed well while others have not.[2] Data that exists may be unevenly collected, omit core contextual factors affecting care including data on the workforce or be limited to settings and/or countries that are not representative of where the majority of older adults receive residential long-term care.

In terms of the immediate response required to address the current COVID-19 pandemic in nursing homes, we provide some considerations for nursing home leaders and regulators to support the health and well-being of nursing home staff and residents. These are categorized into four main areas: clear direction and guidance, keeping staff healthy, human resource policies, and implementing new clinical changes. Our recommendations stem from what administrators and organizations of nursing homes have brought forward from our international community of researchers and points to several strategies that could be adopted (Table 1). First, the provision of clear directives and guidance in keeping staff informed is critical, especially as the advice from experts evolves as they learn more. Our proposed strategies include incorporating daily huddles, messaging platforms that are safe and secure to enhance timely team communication and curating useful resources and documents that can be easily accessible online for staff, residents and their relatives. Second, the strategies to keep staff healthy focus on stress management and meeting staffs' basic needs, including providing daily meals and promoting activities to support their health and well-being. Third, providers in most countries focused on implementing human resource strategies, which included offering hazard and sick pay and creatively expanding the workforce. Finally, in light of COVID-19, there is a greater need for new practices such as supporting end-of-life care. In response to this need, nursing home leaders should implement education/training opportunities to ensure that staff acquire the knowledge and skills related to these new clinical changes and directions. One important policy level consideration advocated for in many countries included an immediate expansion of the workforce in nursing homes by making changes to registration, certification and credentialing. Table 2 provides considerations for improving infection control and prevention strategies offered by various providers internationally and from countries that have developed recommendations to support their staff by focusing on education and training related to personal protective equipment (PPE), maintaining restrictions, and acquiring PPE.

For longer term solutions, our consortium of researchers propose that, at the policy level, an essential redesign of nursing homes globally is urgently needed to combat the poor public image of nursing homes, address a funding system that is broken, improve the working conditions for staff and address the lack of meaningful data to monitor and develop practice. Our main recommendations include a focus on leadership, increased attention to the complexity of health

issues reflected in the nursing home population and enhancing the capacity of nursing staff and interprofessional team members.

1. Leadership. In 2001, an Institute of Medicine (IOM) report on quality in nursing homes identified nursing management and leadership as a central factor in the provision of high quality care.[19] Despite this, and numerous studies identifying the importance of strong, skilled leadership, formal training and preparation to lead and manage nursing services is not guaranteed,[20] and thus we have seen a widespread failure to recognize and effectively respond. Standards for leadership education and skill development among nurses in leadership positions has lagged significantly behind non-nurse administrators. The importance of strong leadership skills is clearly reflected in the actions of adaptive nursing leaders who have successfully supported staff through the pandemic and created opportunities where residents continued to experience human connectedness with persons important to them. But we can no longer leave it to individual nurses to develop effective leadership skills on their own.
2. Residents' needs. We have staffed the majority of our homes to provide social care for long-stay residents and have forgotten that most of the residents today need health care as well, given the complex health issues facing persons living in nursing homes. In order to maintain the physical, social, emotional and cognitive function of residents, we will need to be able to assess and intervene to preserve functioning for as long as possible, regain lost function when there is the potential to do so and adapt to lost function that cannot be regained.[21] Fulfilling this remit will require being open to innovation and technologies and enhanced training and support for staff.
3. Interprofessional teams. Redesigning roles and building capacity of nursing staff working in nursing homes and ensuring our interprofessional team members can contribute to this end goal while being supported by adaptive leaders could positively influence the recruitment of a new generation of staff in nursing homes. The need to base this work in a more meaningful person-centred philosophy of care that is evidenced informed, relationship-centred, appreciative and compassionate is the uniqueness of working in nursing homes.

Conclusion

Nurses and nursing assistants working in nursing homes are invaluable members of society and work in care environments where many others are unwilling to work. The key message for policy makers is that we need to bring to the forefront the critical role of leaders and their capacity to effectively lead in nursing homes, which are complex environments. During this unprecedented time in our history, we should be thankful for all staff working in nursing homes. They are the de-valued work force and, in some countries, the forgotten. A reckoning of how we treat staff working in nursing homes is required. The COVID-19 pandemic foreshadows the terrible consequences of not responding with urgency.

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174 **Table 1** Considerations for Supporting Staff in Nursing Homes

Provide Clear Direction and Guidance

1. Promote daily huddles with staff to provide updates and address concerns.

2. Provide more 1:1 engagement between supervisors and staff with an emphasis on appreciation of the work being done.

3. Develop a leadership group that is available 24-hours a day to communicate information and provide hands-on support to staff.

4. Consider the use of messaging platforms (e.g. a national and multiple regional WhatsApp group) to efficiently disseminate guidelines to managers and staff in a timely manner.

5. Encourage managers to prioritize the ongoing communication with infection control officers.

6. Curate useful and clear resources for staff, residents and their families, post them online in an easily accessible format and broadly disseminate information.

7. Ensure at least one manager is physically present to address staffs' questions and concerns on all shifts.

Keep Staff Healthy

8. Pay close attention to the emotional health and well-being of staff and offer stress management as well as grief support services without cost to staff.

9. Provide daily meals and snacks to staff, as well as open a 'quick market' so staff can buy food before returning home.

10. Keep staff motivated and support staff morale by displaying letters of gratitude from families and the public in walkways.

11. Maintain weekly virtual rounds between medical care providers, consultants and nursing home staff to discuss clinical care issues.

12. Assure staff appropriate hours including no overtime and provide rest periods to avoid burnout.

Implement Human Resource Policies

13. Optimize the use of health sciences students.

14. Implement hazard and sick leave pay and offer full-time employment and staffing flexibility.

15. Increase staffing by redeploying and educating staff from other healthcare facilities, such as hospitals, to work in nursing homes

Implement New Clinical Practices Related to COVID-19

16. End-of-life care including advanced care planning, symptom relief and postmortem care.

17. Human connectedness strategies to minimize resident isolation.

18. Policies regarding transfers to and from hospitals of COVID-19 residents.

19. Decision-making guidelines for developing infection control and isolation care plans. *

175 * Ethical guidance for people who work in long-term care: What is the right thing to do in a
176 pandemic?; (https://bit.ly/dementiatoolkit), Accessed May 23, 2020.

Table 2 Considerations for Improving Infection Control and Prevention Strategies in Nursing Homes

Education and Training

1. Encourage staff to stay at home if they are experiencing any signs or symptoms, and ensure alignment with human resource policies.

2. Provide weekly preparedness training with staff so they are confident in their ability to respond.

3. Prepare and distribute updated videos and other resources for staff on how to use and dispose of Personal Protective Equipment (PPE).

4. Redeploy experienced nurses to ensure that staff follow PPE guidelines and assist with the donning and removing of PPE.

Promoting Protective Practices (Guidelines now available in many countries which continue to be updated: See below for examples)*

5. Maintain visiting restrictions within the nursing homes, limiting and screening anyone entering the home.

6. Screen nursing home staff and essential care partners for COVID-19 on a routine basis.

7. Provide education for anyone in nursing homes which includes hand hygiene, respiratory etiquette and the promotion of physical distancing between everyone, including during break times.

8. Consider encouraging staff to reduce the transmission risk by staying in nursing homes for extended periods of time, or other accommodations, if possible.

9. Practice inclusive surveillance protocols for residents under investigation which include assessment twice daily for possible signs and symptoms of COVID-19, including fever, cough, shortness of breath, and other atypical symptoms, such as hypoactive delirium, deterioration in activity, and loss of appetite.

10. Implement the universal use of face masks for all health care staff and visitors in long-term care facilities.

11. Develop a workflow plan for when a COVID-19 resident is identified.

Acquiring PPE

13. Request PPE from national stockpiles.

14. Campaign to public and private donors to obtain necessary PPE.

*Notes: Examples of Guidelines From Several Countries

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