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

7 **Uncovering the Devaluation of Nursing Home Staff During COVID-19: Are We Fuelling** 8 **the Next Health Care Crisis?**

9 As the COVID-19-related mortality rate of nursing home residents continues to rise, so too will
10 the rates of mortality and morbidity of staff who care for them,¹ a problem we must address now
11 to avoid another health care crisis once this pandemic recedes. Currently, a significant
12 proportion of deaths are attributed to persons living in nursing homes, ranging from 42-57% in
13 European countries reporting data² to as high as 82% in several U.S. states and in Canada
14 reporting data.^{2,3} However, there is a concern that many countries are not including nursing
15 home deaths in the death toll. While not reported globally experts predict, the majority of health
16 care workers who will die from COVID-19 are nursing staff (nurses and nursing assistants)
17 working in nursing homes.¹

18 Most residents in nursing homes are over the age of 80 and have multiple chronic conditions and
19 are at risk of COVID-19. However, several factors unrelated to the residents themselves increase
20 their vulnerability to COVID-19 as well as members of nursing home staff. The pandemic has
21 laid bare long-standing structural deficiencies affecting the nursing home sector. Chronic
22 understaffing in nursing homes is a global concern, which makes providing basic care a
23 challenge, and has made monitoring residents for COVID-19 symptoms even more difficult.⁴
24 Understaffing also undermines a staff's ability to follow protocols to keep residents physically
25 distant, as public health measures to reduce the transmission of the virus including isolating
26 residents when COVID-19 positive can exacerbate behaviors in residents with dementia who
27 may not understand or follow the procedures.⁵ Staffing levels in nursing homes continue to be a
28 concern globally.⁶ Precarious work conditions characterized by part-time employment, heavy
29 workloads, punitive measures related to sick time, low wages and an obligation to work when
30 sick⁷ contribute to a global staffing crisis in nursing homes. Family members and other
31 volunteers have frequently provided supportive care in the past, but with the visitors ban due to
32 COVID-19, this support has vanished, further exposing the vulnerabilities and consequences
33 associated with chronic staffing shortages. Nursing homes are working under capacity, as staff
34 have tested positive for COVID-19 symptoms.¹ At the same time, some countries report
35 significant rates of staff absenteeism or abandonment of their work due to fear of getting the
36 virus or transmitting it to their loved ones.^{8,9} This fear is not unfounded, as many staff providing
37 the most hands-on, direct care in nursing homes (e.g., bathing, assisting with meals, etc), are
38 women, who have double or triple caregiving responsibilities⁷, with a low socio-economic status
39 that cannot risk income loss regardless of working conditions, and are at high risk for poor health
40 outcomes if infected. Also, it is known that staff are most likely spreading the virus within
41 nursing homes¹⁰ especially because many who are subject to low wages and the part-time
42 employment culture are forced to work at multiple nursing homes in order to earn a livable wage.
43 The expected grief, guilt and moral distress of losing residents they have cared for over many
44 years, the moral injury related to working under high pressure and possibly violating their own

45 ethical or moral codes¹¹—coupled with the potential guilt of their own role in transmission – will
46 need to be addressed.

47 The COVID-19 pandemic has also revealed and accentuated the ageism and devaluing of older
48 people pervasive in many societies.¹² By association, the nursing home staff workforce also
49 experiences devaluing, a long-standing reality which has become more apparent as the pandemic
50 expands globally. The public campaign ‘clap for medical staff’ worldwide¹³ and ‘clap for those
51 in the National Health Service’ in the UK¹⁴ initially appeared to ignore staff in nursing homes.
52 Shortly after, the slogan was changed in many countries to ‘clap for carers or health care
53 workers.’ While anecdotal, the initial messaging implies that nursing home staff are often an
54 afterthought, frequently ignored in health care system conversations.

55

56 One of the most blatant signs of devaluing older people in nursing homes and their workforce is
57 society’s failure to keep nursing home residents and their staff safe. Most of the initial
58 government COVID-19 guidelines took a hospital-centric approach and focused largely on
59 nursing homes as venues for discharge. While our acute care hospitals were encouraged and
60 enabled by their governments to gear up and order supplies for their staff, where was the
61 pandemic planning and supplies for nursing home staff? Unprecedented times call for
62 unprecedented measures for everyone. Eventually official documents that provided specific
63 guidance about how to manage pandemics in nursing homes emerged in several countries, but it
64 is unclear how this information was transferred to the numerous nursing homes and what
65 supports were being provided to facilitate the uptake of this new information within individual
66 nursing homes. As an acknowledgement to the care sector for their contribution, the Secretary of
67 State for Health and Social Care in the UK launched an initiative consisting of a ‘CARE’ badge,
68 which was met with backlash from nursing home workers, the workers declaring, ‘don’t give us
69 a badge, give us PPE’.¹⁵ Their sentiment was echoed by staff in the United States¹⁶ and
70 confirmed by accounts reporting that 70% of nursing home providers were unable to find
71 sufficient supplies for their staff.¹⁷ Whilst the delays associated with PPE provision in nursing
72 homes partly reflect the logistical challenges of getting equipment to a large number of dispersed
73 facilities, the failure to prioritise such planning earlier has served to further marginalise this
74 important group of healthcare professionals, at a time when they need more support and
75 recognition than ever. Two months into the pandemic, many staff in nursing homes globally
76 continued to work without PPE¹⁶ and the serial changes to guidelines had left them confused
77 about what equipment to use and when. While the pandemic brings extraordinary challenges to
78 healthcare settings across the continuum, the disproportionate risk of COVID-19 spreading in
79 nursing homes demands greater attention, to protect our most vulnerable populations and the
80 staff that provides their care.

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

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

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

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

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

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

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

160

161 **Conclusion**

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

170

171

172

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.

178 **Table 2** Considerations for Improving Infection Control and Prevention Strategies in Nursing
 179 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.

180 *Notes: Examples of Guidelines From Several Countries

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