Research Report

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UCSF Health Workforce Research Center on Long-Term Care

In the trenches: Front-line workers' burnout experiences in long-term care settings in the COVID-19 pandemic

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Introduction

Burnout is an occupational syndrome originating from the imbalance between job demands and resources that people in any profession can experience, yet it is a distinct workplace phenomenon that requires organizational-level solutions (1,2). Negative consequences of burnout in healthcare include increased anxiety and depression among workers, lower quality of care, limited services, and a lack of preparedness for health crises.

For years burnout has been recognized as an occupational hazard especially in people-oriented professions (2). Emotionally demanding and challenging work together with lack of resources and effective leadership are causing burnout and leading to nursing turnover(3). The COVID-19 pandemic exacerbated the burnout already felt by healthcare workers and forces health systems to deploy strategies to address the unpresented financial, physical and emotional burden for both workers and employers (4). The pandemic has also highlighted how pre-existing societal inequities are exacerbated in times of crises.

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There are nearly 7 million underpaid, yet essential, front-line workers in the U.S. (5), such as nursing home technicians, home health aides, medical and nursing assistants, food service, and housekeeping staff but often they are not considered part of front-line healthcare workforce compared to other professionals such as registered nurses and physicians (5,6,7). Furthermore, front-line workers in low-wage positions are likely to be women, immigrants and people of color (6,7). Also, due to their lower socioeconomic status front-line workers are at greater risk of losing their job, and suffer from caregiver burden (6,7,8,9). Since the beginning of the COVID- 19 pandemic, many front-line workers, such as CNAs, did not receive hazard pay, pandemic-specific training, or appropriate personal protective equipment (PPE) on time (10). Given employment-related demands (e.g., physical and emotional stressors, low pay leading to inability to meet personal needs, low hierarchical position in the organization) front-line workers are also likely to experience physical, mental, and financial hardship. (5,11,12).

The COVID-19 pandemic has been an unparalleled challenge to healthcare systems including long-term care settings. The pandemic has hit specifically hard nursing homes which are known for the poor quality of care. Issues such as abuse and neglect are not always reported, complaints are not addressed promptly, penalties regarding violations are not always administered appropriately, persistent low staffing and disparities in quality between racially different nursing homes (9,13). Given the known challenges of quality in long-term care together with the issues brought by COVID-19 pandemic and lack to documentation of nursing home workers experiences it is critical to address the needs of these essential front-line workers and identifying best practices in supporting and preventing burnout in long-term care settings (6,13). To understand the unique experiences of front-line healthcare workers in long-term care settings and identify necessary support strategies, we conducted in-depth qualitative interviews with workers across a variety of long-term care settings. Our aim was to assess stress and burnout to gain insights about how long-term health care systems can best promote worker safety and well-being in times of crises.

Methodology

The study used a qualitative approach to illustrate front-line workers' experiences in the beginning of the COVID-19 pandemic and identify necessary strategies to support them. A qualitative approach allows front-line workers'

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voices to be heard and used as guidance to develop support systems in response to the continuing pandemic (14). Our research questions were:

1) What are the primary sources of stress that contribute to burnout of front-line workers across the long-term care settings of the health system from the beginning of the COVID-19 pandemic, to date?
2) What strategies can long-term care health systems employ to support front-line workers in the COVID-19 pandemic?

Registered nurses or vocational nurses were not included in this study. This study was approved by the Institutional Review Board (IRB) at University of California San Francisco.

Sample, data collection and analysis

Participants were recruited through existing contacts in a few nursing homes in Northern California, through Facebook ad and researcher colleagues in East Coast Area by using purposive and snowball sampling methods between January and August 2021. Snowball sampling became the most fruitful recruiting method since many participants were able to refer other participants. Inclusion criteria were that they: worked as a front-line worker (e.g., certified nursing assistant, food preparer, housekeeper, janitor, medical assistant) in a long-term care setting (e.g., skilled nursing facility, home health, rehabilitation); could communicate in English; and were over 18 years of age.

Data were collected through 45-minute-long semi-structured phone interviews conducted by a member of the research team. A qualitative interview guide was created with open-ended questions to encourage participants to speak freely (14,15). Questions focused on four different areas: demographics, the COVID-19 pandemic impact on participants and their work, COVID-19 pandemic impact on participants and their family and take-away messages from participants about their experiences working during the COVID-19 pandemic.

Otter.ai™ software was used to record and produce transcriptions of the interviews, and the ExpressScribe© application was used to clean the transcriptions. Interviews were arranged with participants according to their schedules to ensure they felt comfortable to participate and could focus on the interview. Verbal consent forms were emailed to participants a few days before the scheduled interview, so the interviewees had time to review

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and ask questions at the beginning of the interview if desired. After completing the interview, a $50 gift card was emailed to the participants to compensate them for their time.

Once the interviews were complete, the research team read and coded the transcripts. The first research team member coded the transcripts manually. A second team member coded the transcripts using qualitative analysis software called Dedoose ™to increase the rigor. The results of these independent codings aligned with each other. After independent coding, the first team member assessed the emerging themes through thematic analysis and formed the final themes that best reflected participants' experiences during the pandemic (14,15). Thematic analysis is considered a method for identifying, analyzing and reporting patterns to a research process in which qualitative data are first read and re-read. From there, the researcher generates initial codes, identifies themes, reviews the themes, and defines and names the final themes (16,17).

Results

A total of nine participants were eligible to participate, and all were interviewed. All (n=9) were female. The majority of participants (n=5) were from the metro-New York City area, followed by California (n=2), Florida (n=1) and Texas (n=1). Most participants worked as CNAs (n=6). The remaining participants worked as a housekeeper supervisor (n=1), interpreter (n=1), or activity coordinator/CNA (n=1). Work experience varied between 7-17 years, where seven participants had 10-17 years of experience. All CNA participants had completed federal and state approved CNA education for their job. Three overarching themes were identified that impacted these front-line workers' feelings of burnout: COVID-19 impact on the work environment, material resources provided, and COVID-19 impact on the worker.

COVID-19 impact on work environment

Increased burnout

All participants (n=9) emphasized experiencing increased workload and stress since the pandemic started in Spring 2020. These increases in workload, and thus stress, were largely a byproduct of staffing changes, which were both directly and indirectly influenced by the pandemic. Direct influences to staffing changes included workers needing to quarantine after COVID-19 exposure; needing to take sick leave if they contracted COVID-19; and in some facilities (particularly the metro-NYC area), dying of COVID-19 in significant numbers. For these reasons, many CNAs ended up working extra shifts: *"Everybody like myself, being a CNA, we had to do the*

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double work…Because we lost a lot of staff, and lot of staff end up being drained or burned out." Indirect influences, namely facility-level policy changes, also contributed to staffing changes. Interviewees described that staffing policies varied from facility to facility. In some cases, facilities required workers to work only in COVID or non-COVID units, which limited staff's ability to flex across units. In other cases, workers were often moved between units. One participant felt that COVID-19 spread quickly in her facility because employees were moved between non-COVID and COVID floors instead of keeping the same staff assigned to the COVID floor all the time: *"There are floating CNAs (who do not have an assigned floor) who switched floors every day. And that's when the problem [more COVID infections among the staff] started."*

Persistent organizational policy changes

Another factor that contributed to workers' increased burnout were frequent workplace policy changes and unclear communication regarding new rules. One CNA stated, *"Policies were changed constantly because the health department or whoever came in to inspect and make sure that we were doing things right".* A second CNA also commented on communication and policy changes: *"And then management, you have management telling you something, you're listening to [them] and then you hear something else [from the management]. It was confusing, Jesus Christ, it was confusing."*

In addition to CNAs, housekeepers also experienced organizational policy changes, which affected their job responsibilities and contributed to burnout. Many facilities required housekeeping staff to take additional precautions and measures with disinfecting procedures; more rules were established, and additional steps needed to be followed, including the wearing of PPE, to comply with these new rules. This had a significant impact on housekeepers' workload. One housekeeper said, *"In this pandemic, we are doing more jobs, wiping down the high touch areas every two hours. Also, every day, residents exercise outside, so we sanitize the chairs. We disinfect the wheelchairs and walkers for breakfast, lunchtime, and dinner. Everything needs to be wiped down and sanitized. We wear the PPE differently; we really need to wear everything: face shield, mask, and isolation gown."*

Multiple roles

Often, staffing restrictions that limited those who could enter COVID units in long-term care settings contributed to feelings of burnout. These restrictions prevented certain professionals, such as housekeepers, phlebotomists, and

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chaplains, from tending to COVID-positive patients. As a result, CNAs, who were allowed in the units, had to take over these duties in addition to their usual responsibilities. One CNA said, *"We're doing janitor's work, we're doing housekeeping, on top of CNA work, because there weren't staff to do that."* Another said, *"…I basically would end up being the minister; that church service person going into the room, praying with them, just making sure to let them know that everything is going to be okay."*

Provided material resources

Bonus and hazard pay

In the metro-NYC area, CNAs experienced local variations in receiving bonuses, commonly referred to as "hazard pay." One CNA indicated that "*We know that there are many nursing homes and hospitals where the front-line workers are receiving a bonus or [extra] money. Our facility never provides us anything. When we questioned it, they [management] said they give us free lunch. So that money will go to the sandwiches that they were serving us for the first two months"*. Another CNA also described differences in provided resources: "*With everybody that I am surrounded with in different facilities, hospitals, their experiences are a little bit different from ours… My sister-in-law, she worked at a different facility…So, I know that other facilities were doing it [giving monetary bonuses], but ours, they did do nothing."* Most participants received monetary bonuses, but the amounts varied significantly between states. Most interviewed CNAs in the metro-NYC area said they received a one-time bonus of $400, leaving them with $240 after taxes. However, one CNA working in metro-NYC area commented that some workers received more money than others: *"Well, some of them [CNAs] who worked in more than one nursing home there. We talked about the difference between facilities. Like I told you, some CNAs get money every week. Like a little bonus check. Every week, different from the pay. When we didn't get that. We got only one time ($400)*." In California, an interviewed CNA stated that her salary increased $3 per hour which she called as a hazard pay, but no additional one-time bonus money was given.

In California, the housekeeping staff interviewed said that her salary increased $2 per hour, and they received a $1000 bonus twice from the employer during 2020. In Texas, one CNA working on the COVID unit was compensated with double pay. Moreover, in her facility everyone equally (e.g. housekeepers, nurses, and CNAs) received $250 or $500 bonus every three months, although further details of this were not provided. All interviewed participants described using their extra money for food, bills, and fuel.

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PPE availability

Another frustration that contributed to burnout among the participants included availability of PPE. Californian and Texan participants expressed that they did not have issues with having PPE readily accessible in their workplaces. However, in the metro-NYC area, PPE availability varied. In one nursing home, gloves were available at the start of the pandemic, but masks and face shields were not. One participant said, "*We always have gloves, but when it [the pandemic] started, the masks, and the shields were not available at that time. It [masks and face shields] was just added. And then this lady [infection control] was saying that we don't need it. That's why she ended up getting fired."* Another CNA described "smuggling" PPE into the patient room by putting the gown on inside the room instead outside where isolation gown is usually put on prior to entering to the patient room. In this facility, workers had been instructed that PPE was not needed in non-COVID rooms, but the employee did not feel comfortable working without PPE given that the resident may be COVID positive before symptoms appeared. According to the participant, this was a standard practice at the beginning of the pandemic when there were dedicated rooms for COVID-positive patients on the general floor, but not separate floors for these patients.

One CNA described an event when PPE was available but not automatically provided. Instead, a nurse had to defend the CNA and demand that management provide appropriate protection: "*Then one time, there was a patient who died. One nurse said 'I am not gonna touch the dead body, and I am not going to let my CNAs touch the dead body until you guys provide us PPE.' [The facility manager said] 'No, we don't have [PPE]; we're very limited.' The nurse said, 'People are dying. What do you mean limited on them? We have to use them.' Then she [the nurse] threatened to call the governor's office. When she said that, within an hour, oh my gosh, we had like four or five boxes of masks, gowns, face shields. Everything. It makes us show a certain way [lack of respect and appreciation from the employer towards CNAs]. Why did they [management, leadership, administration] have to treat us like this?"*

Union support

Information regarding available resources offered by the unions was disseminated through brochures, emails, flyers in workplace break rooms, and/or direct phone calls and letters to members. However, due to a mandated curfew in metro-NYC area and other pandemic-related restrictions, such as social distancing and closed offices, many participants could not access or use the available resources.

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All participants in the metro-NYC area were members of a labor union. The participant in Texas was not part of a union, and the Californian participants did not speak about their union involvement. Some participants from the metro-NYC area felt that their union tried to support them as much as possible by generally offering good health insurance benefits (which also seemed helpful during the pandemic) and hot lines or classes for their mental health needs. One participant said, "We have a good union. They provided us. They have insurance for us and our family". A few participants felt that the union did not provide necessary or appropriate support, especially when laying workers off at the peak of the pandemic. One interviewee said, *"They didn't do the proper seniority thing. So, now there is confusion [about the seniority rule]. That's how the union [is] supposed to come in, and I hope they can* fix *it [investigate what happened]".*

Community and organizational support

As mentioned earlier, participants in Texas and California did not have unions or they were not members of unions. However, they were given extra pay (e.g., bonus and/or hazard pay), free food, discounted hotel rooms for quarantine, the option to sleep at the workplace between shifts by their employer. Also, psychologist appointments via Zoom, free transportation between home and work, access to the facility's laundry room to wash uniforms, and schedule flexibility to accommodate childcare/homeschooling needs were available for the participant in Texas.

Six participants expressed that the community support they received minimized feelings of burnout. Among these participants, nearly everyone described churches providing help with items such as food and clothing. One participant said, "*Yes, if you are a member of a church, the church gives away food. Sometimes they will give you [enough] that you can give [some] to other people."* Some participants said neighborhood volunteers also provided help with pantry items and clothing, especially for families with kids. One participant said, "*All I had to do was say [to people in my neighborhood] , 'We have staff members who are needing food and groceries,' and [the neighbors] were nice enough to buy food, leave it at the front porch, put [groceries] on the table of anybody that needed it."*

Also according to a few metro-NYC participants, public transit was free of charge for front-line workers; however, some did not want to use it because of potential additional exposures to COVID-19.

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COVID-19 impact on the worker

Emotional burden & exhaustion

Participants working in nursing homes, especially in the metro-NYC area, described the personal and emotional impact of many of their residents dying from COVID-19 on a daily basis. All participants had relatively long work experience in their industry, and many had worked with/for the same residents over the course of those years. Participants were often emotionally bound to their residents and were distressed to see their residents suffering. Caring for the residents during the disease process and witnessing their unavoidable death was an emotionally traumatizing experience. One CNA said, *"And one day sometimes, six to ten patients died. And we have to go through all this. I mean, there's a time I forgot about myself because when you're dealing with all this kind of stress, and you see what family members are going through. It just makes you feel kind of numb. That's how I felt. You feel like there's no hope for us."* Another CNA described a similar experience: *"I was working on the COVID unit most of the time. It's like a traumatic experience, I am telling you; going in every day, seeing them (sick residents) groaning, laying down just like that…And then they die, no matter what you do. You come next day, somebody dies on you, but you just get back [to work]."* To manage this kind of emotional stress, participants reported utilizing coping mechanisms such as meditation, individual prayer, bible studies, and focusing on family members.

Lack of professional respect & appreciation

Participants in the metro-NYC area, compared to participants in other regions, expressed experiencing a lack of respect and appreciation from their employers and society during the pandemic. One participant described how management did not seem to care about what the workers went through during the height of the pandemic: *"When we hear that other people working in other facilities are receiving higher bonuses than us and we bring it to them [management/administration]; they don't want to hear it. It pushes them away. They don't want to hear it. It's not about the bonus really. It is about what we went through. No money, nothing can change that but at least make us believe that they [management] care about us. Don't treat us like that. I mean, we have family members and many of them were sick. A lot of people had no place to stay, and many lost their job, but they [management/administration] don't care".* In contrast, participants in California, Texas and Florida expressed a more positive image of their employers in regards them being more caring and supportive towards the workers. A Californian participant described her employer proving great support: "My boss was very generous about trying to

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help us out as well. If we needed to stay, there because at the time we were having patients (with COVID). We would still come and go. We had a few empty rooms, he was willing to offer us that, just to prevent the spread of it, being taken home to our families. He made sure we were fed. He made sure we were taking care of.".

A few participants described the depth and complexity of issues involving CNAs working in a hierarchical industry. One said, *"When COVID-19 was going on, everybody was talking about the nurses and doctors and all of that, but nobody talked about CNAs. Nobody thinks that we had that terrible experience also. Like everybody else. You know because we did. There are people to whom we are really attached. And these are people [residents] who we are taking care of every day. They are no strangers coming in and dying…I remember one day; they said McDonald's is offering free breakfast to healthcare workers. And we drove up to one McDonald's, and she (restaurant staff) said to me, 'Oh, it's not for CNAs. It's not for you working in a nursing home; it is only for nurses who work at the hospital.' That was so weird. It wasn't a nice feeling. All the time though, not only during COVID-19, people look down at us as CNA workers."* This quote illustrates the inequality between low-paid, front-line workers and nurses/other healthcare professionals that existed during and prior to the COVID-19 pandemic.

Job security and status

The lack of job security also contributed to participants' feeling of stress and burnout. In the metro-NYC area, interviewed participants said that their workplaces experienced many COVID-related deaths among their residents; as a result, many facilities had to close down units. This caused layoffs to start occurring in spring 2021. After working diligently through the pandemic without appropriate emotional support, the layoffs were experienced as a disrespectful gesture for employees: "*And then … they start to lay off people…That is that; after all you go through, all this helping. And this is how they are taking you."* Job insecurity can promote emotional exhaustion and burn out (18). One CNA participant was laid off and was able to find a new CNA job, although with a population different than elderly residents. Another CNA took a second job at the height of the pandemic because she did not feel secure with only one job. In contrast, participants in California, Texas, and Florida did not express concerns regarding job security.

Six participants reported that the pandemic made them question whether they wanted to stay in their current job, and five indicated that they planned to make a career shift. Some planned to study a new healthcare profession,

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and some reported that they wanted to leave healthcare altogether. Others planned to retire and/or hoped to find part-time work that could be completed at home.

Discussion

Since COVID-19's introduction, the aftermath of the pandemic has created a new global reality that has changed how we work, live, and play. In particular, the pandemic has significantly affected the long-term care sector. Our study explored how front-line workers in long-term healthcare settings experienced the impacts of COVID-19 to learn which strategies these systems can employ to best support front-line workers during the pandemic.

Several key themes emerged from our interviews. Front-line workers reported not receiving respect for their role in caring for patients during the pandemic, which other research confirms has been a prolonged issue (22). The pandemic also created new and significant stress in the work environment leading to emotional exhaustion and burnout among all types of front-line workers. Although some resources were provided by workers' workplaces and unions to lessen COVID-19's burden (e.g., bonuses, mental health resources, free food), these resources were often not enough to support them, especially considering their increased workload, or there were disparities in providing the resources between organizations and locations.

Some participants received additional support from their local community, but even so, gaps in needed resources remained. In totality, the pandemic significantly affected workers' intention to stay in their roles, which caused many to plan or start thinking about making a career shift. In contrast to other studies, participants in our study discussed monetary compensation (e.g., hazard pay, bonuses, raises) received (or lack thereof) during the early pandemic. While our participants did not directly express having financial challenges in meeting basic daily needs, Ecker et al. found that financial insecurity was a reality for many participants (22). The contrast in how and in what amounts certain front-line workers were compensated highlights the potential for policy change to standardize received benefits to reduce inequalities.

Other studies exploring front-line healthcare workers experiences during the COVID-19 pandemic have also found increased workload, stress, anxiety, and emotional exhaustion due to lack of staffing, lack of professional respect, constant policy changes, and lack of/disparities in providing emotional or material resources for low-paid

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front-line healthcare workers. (19-27). Our results line up with other findings, yet it is unfortunate to see the same problems regarding healthcare workers burnout and lack of respect remain year after year and how crisis like current pandemic magnifies it. Our participants' experiences together with other studies offer evidence that burnout and promoting factors in long-term care are foundational issues and crises like the COVID-19 pandemic make them worse. It would be critical to use the research evidence when creating policies that would support frontline workers in their everyday work outside of crisis times and so for be better prepared prolonged crisis such as still existing COVID-19.

Recommendations

Overall, study participants reflected professionalism and a strong dedication to their career, largely motivated by the deep care they held for their residents. However, front-line workers should not continue to provide essential elder care without sufficient monetary compensation, emotional support, and professional respect. Long-term care systems should develop worker well-being programs and include emotional support in those. Moreover, employers need to ensure that workers can access services easily meaning that there is time for meetings with psychology, leadership etc. during the workday and available on the work site. Furthermore, given that front-line workers such as CNAs are considered to be low in organizational hierarchy strengthening and elevating front-line workers' position as equal and essential members of the team in long-term care organizations would be vital. This could include increasing financial compensations, updating regulatory requirements for staffing standards in nursing homes, developing/modifying current training and competency standards to better meet the needs and challenges of current healthcare (including long-term care), advancing and empowering workers, and changing the narrative of front-line workers through public education campaigns to enhance worker visibility suffering from the effects of systemic racism (28,29,30). By improving monetary compensation related to special situations like a pandemic, organizational leadership should ensure that their policies and budgets allow front-line workers to be appropriately and equally compensated so that workers are not dependent on external resources.

Limitations

Limitations of this study include the small sample size and the snowball sampling method. However, reaching nine participants during the COVID-19 pandemic can be considered appropriate for a qualitative study where the focus is to hear participants' authentic experiences regarding the researched phenomena. Participants provided rich descriptions, which enhanced authenticity, and we reached thematic saturation despite having only nine

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participants. Furthermore, marginalized front-line workers such as CNAs may hesitate to discuss their unpleasant experiences out of concern for facing backlash from their employer. A few of the CNAs who contacted us feared retaliation if they participated.

Conclusion

This research is timely and relevant given the lessons learned as a result of the COVID-19 pandemic and a renewed interest in how to better care for front-line workers (10, 30). As the pandemic has illuminated, front-line workers are essential to the care of the frailest elders, yet the supports they receive to enhance their job and prevent burnout are non-existent. Identifying resources that prioritize those who are working "in the trenches" can transform the industry among this rapidly expanding, essential workforce.

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