Reflections from the “Forgotten Front Line”: A qualitative study of factors affecting wellbeing among long-term care workers in New York City during the COVID-19 pandemic

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ABSTRACT
While long-term care (LTC)1 facilities serving older adults have long struggled with low employee morale and high rates of staff turnover, the COVID-19 pandemic brought unprecedented challenges to these facilities and the frontline staff working in them. This study aimed to explore factors that influenced the personal and professional wellbeing of care providers working in LTC facilities across New York City (NYC) during the pandemic. Fourteen semi-structured qualitative interviews were conducted with frontline care providers working in LTC facilities across NYC. Interviews were audio-recorded, transcribed, and systematically coded according to both pre-existing and emergent topics. Four main themes emerged from the data: the toll of the virus; home and work-life balance stressors; workplace stressors; and participants’ recommendations for facility leadership. Findings from this study may inform strategies for supporting the wellbeing of frontline care providers in LTC environments, especially during future public health emergencies.

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Introduction
Employee burnout and low staff morale are well-recognized, common problems facing long-term care (LTC) facilities serving older adults. While estimates of turnover in nursing homes vary, one recent study reported annual turnover rates as high as 141% among registered nurses, 129% among certified nursing aides, and 114% among licensed practical nurses. High levels of employee dissatisfaction and burnout in these settings are often attributed to the challenging conditions and responsibilities faced by employees in LTC settings such as performing physical labor (e.g., frequently transferring patients between beds and wheelchairs), providing dementia care, assisting with personal hygiene, and a high proportion of residents who are suffering or facing death.

Job dissatisfaction and burnout among care providers in LTC facilities have been linked to high rates of staff turnover and lower quality care for residents. For example, studies suggest that LTC staff members experiencing burnout are less likely to perform key tasks such as comforting and talking with residents, performing patient surveillance, teaching and counseling residents and families, and developing or updating care plans. Other research suggests that LTC facilities with higher levels of staff dissatisfaction and burnout have worse patient outcomes, including higher rates of residents with pressure ulcers, hospitalizations, pneumonia, falls, and weight loss.

While LTC settings have long faced challenges related to employee morale and turnover, the COVID-19 pandemic brought unprecedented challenges to congregate LTC settings serving older adults and the frontline care providers working in them. Until vaccinations became available, LTC facilities accounted for nearly 40% of deaths in the United States (US). New York City (NYC) quickly became one of the earliest epicenters of the COVID-19 pandemic in the US. As a result, those working or living in LTC facilities in NYC were at particularly high risk for exposure to the virus and the associated poor outcomes. By the end of the first wave (February-June 2020), 23,195 probable and confirmed deaths among NYC residents were reported by the NYC Department of Health and Mental Hygiene, almost one quarter of which were among residents of a nursing home.

Studies of the prevalence of COVID-19 antibodies suggest that nearly a quarter of adult NYC residents had been infected with the virus by July 2020, with an even higher prevalence of antibodies among staff (45–50%) in LTC facilities and home health care workers.

The purpose of this study was to further explore the factors that influence the personal and professional wellbeing of frontline care providers in LTC facilities during the pandemic. Fourteen semi-structured qualitative interviews were conducted with frontline care providers working in LTC facilities across NYC. Interviews were audio-recorded, transcribed, and systematically coded according to both pre-existing and emergent topics. Four main themes emerged from the data: the toll of the virus; home and work-life balance stressors; workplace stressors; and participants’ recommendations for facility leadership. Findings from this study may inform strategies for supporting the wellbeing of frontline care providers in LTC environments, especially during future public health emergencies.

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1 LTC: long-term care

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providers for older adults in congregate LTC settings in NYC during the COVID-19 pandemic. Findings from this study may inform strategies for supporting frontline workers in LTC environments, especially during future pandemics or public health emergencies.

Methods

Design

Due to the immediate and pressing nature of the COVID-19 pandemic, this qualitative study utilized an Action Research approach. It aimed to shed light on the experiences of frontline care providers in LTC settings in NYC during the COVID-19 pandemic to fill general knowledge gaps and assist facilities to better support and address the challenges that affect frontline LTC staff who provide care during public health emergencies. Through its entirety, the study remained pragmatic, action-oriented, and centered on the frontline workers and their lived experiences, recognizing that strategies and solutions should be grounded in their concerns, needs, and experiences.

Participant Recruitment

Due to the negative press surrounding LTC facilities and the sensitive nature of discussions on the way the pandemic was handled by LTC facilities and their staff, participants were recruited via public channels external to their workplaces, including public forum websites and listervs targeted to LTC facilities and coalitions and their staff (e.g., professional/trade organization listervs, union listervs, craigslist, social media). Outreach was targeted in order to achieve a sample that was diverse in terms of location of facility by borough and participants’ professional role. Ninety-seven individuals expressed interest in the interviews and provided information on their workplace and professional role via an online screening survey. The study staff then identified a select group of respondents who were diverse in terms of professional role and facility location and conducted a second screening with them via phone to ensure that they were in fact eligible to participate. Respondents were eligible to participate if they were employed as a direct health care staff member (e.g., nurse, CNA²) in a congregate LTC setting (nursing home or assisted living community) in NYC. Fourteen individuals were interviewed. This sample size reflects a combination of time and resources available and anticipated saturation.

The protocol and all instruments were reviewed and approved by The New York Academy of Medicine’s Institutional Review Board. All participants received an interview information sheet and provided verbal consent prior to the interview. They each received a $50 gift card as compensation for their time.

Procedure and Data Collection

Since it was not possible to conduct in-person interviews at the height of the pandemic, semi-structured, one-time telephone interviews were scheduled via phone and conducted between October and December 2020 by staff of The New York Academy of Medicine who were trained and experienced in interviewing and qualitative research. In collaboration with participants, interviews were conducted at a time that was convenient for participants. They lasted 30–65 minutes (mean = 52 mins).

A semi-structured interview guide with 18 open-ended questions and prompts was developed by the research team and used to conduct the interviews. Table 1 includes the full interview guide. Interview questions explored staff perspectives on the COVID-19 pandemic and prompted was developed by the research team and used to conduct at a time that was convenient for participants. They lasted 30–65 minutes (mean = 52 mins).

| Table 1 |
| --- |
| **Interview Guide** |
| 1. Can you briefly tell me about yourself and your job, including where you work, your position and your responsibilities at [facility name]?
| a. How long have you worked there? Do you work full-time or part-time?
| b. Do you work at more than one nursing home? Have you worked at more than one nursing home at the same time in the past? If so, when was that?
| 2. When you are working, how many residents are you normally caring for at one time?
| a. What do you think about this patient caseload? How does caseload affect resident care?
| b. How, if at all, would you change the staffing ratio – or the number people that you are caring for at any one time?
| 3. What is your facility’s sick leave policy for staff?
| a. Do you know if it is different for full- or part-time employees?
| b. How, if at all, did the sick leave policy change as a result of COVID-19? What do you think about the change(s)?
| 4. Were staff offered hazard pay or any financial incentives to work during the pandemic, or the height of the pandemic?
| a. What do you think about this patient caseload? How does caseload affect resident care?
| b. How, if at all, did the sick leave policy change as a result of COVID-19? What do you think about the change(s)?
| 5. How much of an impact did COVID-19 have on your facility and residents?
| a. How widespread was COVID-19 in your nursing home at the height of the pandemic?
| b. Since the initial surge passed, have there been many cases?
| 6. Can you tell me generally about your experience as a staff member at [facility name] during the COVID-19 pandemic?
| a. How, if at all, did your primary responsibilities change due to the COVID-19 pandemic?
| 7. What new policies or procedures were implemented in your nursing home as a result of COVID-19?
| a. When were those policies implemented?
| b. Were you provided with any additional training on infection prevention and control specifically related to COVID-19?
| 8. In your opinion, how well (or not well) did the administration at [facility name] respond to the COVID-19 pandemic?
| a. What do you think the administration at [facility name] did well?
| b. What do you think they could have done better?
| 9. How do you feel about your safety at work now? Was this different during the surge in NYC in the spring?
| a. Was there ever a time when you did not have all the supplies you needed to stay safe? For example, personal protective equipment (PPE), cleaning supplies, or other essentials?
| b. Do you have all needed supplies now? If not, what is missing?
| 10. How did the pandemic impact staffing (e.g., calling out sick, turnover)? What about staff morale?
| a. In your opinion, does staff calling out and/or staff turnover impact your ability to do your job - especially now, during the pandemic?
| b. How could the administration better support employees (and employees morale) right now?
| 11. How did the pandemic change the experience at your nursing home for residents?
| a. What about their families and visitors?
| b. What are your greatest concerns, or challenges, as a staff member at [facility name] related to infection and infection prevention?
| a. How concerned are you about another ‘wave’ of COVID-19 impacting [facility name]?
| b. In your opinion, what do you think needs to be done differently to prevent infections and the spread of COVID-19, since infections seem to be increasing again?

Now, we have some questions about infection prevention and control at your nursing home prior to the COVID-19 pandemic.

13. Prior to the COVID-19 pandemic, what were the most common types of infections that you have seen in residents?
| a. Other than COVID-19, are you aware of infection outbreaks that have happened at [facility name]?
| b. Were there any lessons learned or changes in procedures resulting from those outbreaks? What were they?
14. Prior to the COVID-19 pandemic, what policies and procedures related to infection prevention and control were in place at [facility name]?
| a. How and when were you trained in these policies and procedures? How effective was that training?

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² CNA: certified nursing assistant

(continued)
The last few questions I have for you are focused on what you and your nursing home need to prevent infections in the future.

16. After going through the surge and this pandemic more generally, how confident are you in your nursing home’s ability to successfully manage and/or prevent infections and outbreaks in general in the future?

17. In the coming year, what do you feel you need to do your job effectively, especially when it comes to preventing infections?
   a. What do you need specifically from your nursing home’s administration?
   b. What changes in local, state or federal policies or regulations would you like to see?

18. That’s all the questions I have for you at this time. Is there anything else you would like to share about infection prevention in long-term care facilities?

pandemic and its impact on staff and residents, as well as experiences related to common pandemic challenges such as infection control measures, access to personal protective equipment (PPE), staffing, and employee benefits. Specifically, four questions solicited general work-related information, such as professional role, average daily number of residents for whom they provide care, and sick leave policies. Eight questions solicited respondent opinions on and perceptions of the impact of COVID-19 on work environments, such as implementation of new or revised policies and procedures, administrative response to the pandemic, and workplace safety. Three items focused on information about infection prevention and control prior to the pandemic. Two items asked respondents to describe their facility’s readiness to manage future outbreaks as well as their needs and confidence regarding their own ability to perform their job safely and well. The last question asked participants if there was anything else they would like to share about infection prevention in LTC facilities.

Analysis

Interviews were audio-recorded and professionally transcribed, and transcripts were managed using NVivo 12.0. Two experienced qualitative researchers developed a coding scheme according to both pre-identified topics, derived largely from the interview guide, and emergent topics arising from the interviews themselves. The final codebook was composed of 25 codes, which were grouped in eight major categories, touching on but not limited to the following topics:

- Participant background and experience, including participant role;
- Facility administrative policies, including sick leave and caseload;
- COVID-19 impact, including its impact on the facility, on the participant and their professional responsibilities, and on residents and their families;
- COVID-19 & facility infection prevention procedures, including training, support, enforcement, and oversight related to COVID-19 and COVID-related infection prevention procedures;
- Recommendations, including those for facility administrators.

Codes were used as a means to systematically and efficiently organize interview data, which facilitated the analytic process and helped to reduce bias. Analysis, which was conducted by two qualitative researchers, involved repeated reviews of and discussions about the coded data as well as the transcripts themselves. These repeated reviews and discussions facilitated a more thorough and holistic analysis process, served as a check on the coding, facilitated inter-coder consistency, and helped ensure that coded extracts selected by the researchers were representative of the sentiments expressed by the interview participants and were not taken out of context.

Since LTC frontline staff and facilities were inundated and overwhelmed during the COVID-19 pandemic and due to the time-sensitive nature of the study, this work was conducted without close partners who work in LTC settings and may have – under other circumstances – offered guidance in the design and the analysis phase.

Results

Participants and Facilities

Table 2 summarizes participants’ roles and geographic locations within NYC. Participants included both part-time and full-time employees. They were employed in 12 different LTC facilities (10 nursing homes and 2 assisted living communities). Facilities where participants were employed ranged in size from under 150 beds to nearly 450 beds.14 All but one facility was classified as proprietary business corporations and most had unionized staff members.14,15

Key Themes

Participants consistently reported experiencing stress, anxiety, and trauma during the spring 2020 COVID-19 surge in NYC. Four overarching themes emerged during data analysis: (1) toll of the virus; (2) home and work-life balance stressors; (3) workplace stressors; and (4) recommendations for facilities and administrators to improve support for staff members in general and during a pandemic. Among workplace stressors, three additional subthemes that affected professional wellbeing emerged: (a) perceived administrative support; (b) changes to workload; and (c) safety conditions. Table 3 provides an overview of the themes and examples of supporting data.

Toll of the Virus

Participants described stress and anxiety related to the toll of the virus on their families and the broader NYC community, particularly during the initial virus surge in Spring 2020. They worried about their own health as they were required to report to work in high-risk settings and often relied on public transportation. They also worried about bringing the illness home to family members, particularly children and older adults. Participants discussed the unique stress and trauma they faced as caregivers for their vulnerable older residents. Several described fears of transmitting the virus to residents who were at greater risk of severe disease or death should they contract COVID-19. Those who worked in facilities with a high prevalence of the infection described the trauma of providing care amid an outbreak and losing multiple residents at once.

Home and work-life balance stressors

Participants described a variety of stressful experiences in their personal lives that resulted from or were influenced by the fact that

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b. Were families and visitors informed of infection control policies and procedures? How?

15. How easy or difficult was it for you and your colleagues to follow these infection prevention procedures? What made it easy or difficult?
   a. How much oversight or enforcement was there around infection prevention and control measures in your nursing home? Can you explain?

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Table 2

| Interview Participants |
|------------------------|
| Role                    | N | %  |
| Certified Nursing Assistant (CNA) | 8 | 57% |
| Nurse                   | 4 | 29% |
| Other                   | 2 | 14% |

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1 PPE: personal protective equipment
### Table 3
Key Topics and Themes from Qualitative Interviews with Frontline Staff

| Topic/Theme               | Definition                                                                                                                                   | Example Quote                                                                                                                                                                                                 |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Toll of the virus        | Descriptions of trauma, stress, or other mental health impacts of working during the pandemic, including fears related to contracting and spreading the virus and witnessing the toll of COVID-19 on residents in nursing homes. | Traumatizing. That's the only word I can think of. I slept in my car a few times. I slept in a hotel that I had to pay for out of my own pocket. I didn't wanna bring it home to anybody—. Everyone was really scared. (CNA) |
|                           |                                                                                                                                               | I think the way it affected staff morale, like, I remember one housekeeping guy. He was very upset. He was like, “I don't want to jeopardize my children's health”. I was anxious. (CNA) |
|                           |                                                                                                                                               | But definitely that added pressure [from caring for vulnerable patients] is something, and you can feel it. One false step or one missed move, and things can go really bad. So, I can see people around me, coworkers and the management, they're really stressed. (CNA) |
| Home & work-life balance stressors | Stressors associated with pandemic-related changes at home or that affect work-life balance.                                                | Travel time was impacted. Sometimes your travel time, because of lack of workers with public transportation, it was doubled. So, you know, it took a toll sleep-wise and body-wise on you. (CNA) |
|                           |                                                                                                                                               | It took more time for us to get to work because of transportation, and when we got there we had to wear — change our clothes and put on a special uniform, sterilize our stuff, and put them in a locker, and when we leave we have to take it off and sterilize our lockers. . . it took about an extra 20 – 30 minutes to come in and leave. (CNA) |
|                           |                                                                                                                                               | A lot of people — I wanna say at least 90% of the CNAs and nurses have children which means none of these kids are in school. So, they all have to pay for childcare. Nobody really thinks about that. . . because of no childcare, being short on rent. (CNA) |
| Workplace stressors      | Staff perceptions of administrative support (or lack thereof) during the pandemic, including the impact of these experiences on staff morale and wellbeing. | Whenever we feel like I have a stuffy nose or runny nose, usually before [the pandemic], like you need to find somebody to cover your shift. But now it's been more lenient. (Administrators) listen to us, more understanding that we are taking care of the patients and you don't want your staff to be sick. (CNA) |
| Perceived administrative support |                                                                                                                                              | Understaffed, underpaid, overworked, underappreciated, anything that starts with a U-N, we are . . . The Director of Nursing pretended to have COVID and didn't even have COVID because she was too scared to come to work. The administrator left for weeks at a time. They literally abandoned their staff. (CNA) |
|                           |                                                                                                                                               | I mean, I think [administration] is doing a pretty good job. Like we had . . . a Halloween party for the patients. They gave out little gift cards to all the staff, so no, I think they're doing the best they can, you know what I mean? (CNA) |
|                           |                                                                                                                                               | Let us know that you care about us and about what we're going through. Let us know that we're all in this together. If you're pretty much secluded in your office, and we have to work on the floor short-staffed, what is that really saying to us? We're all nervous, and we're all scared. (Nurse) |
|                           |                                                                                                                                               | We didn't get the COVID pay, which I was mad about, because most facilities did. And I felt that, it's not right. . . If you're going to jeopardize your life and you're standing at the front line, you're entitled to receive it. And I felt very bad that I did not receive that. (Nurse) |
| Workload                 | Descriptions of pandemic-related changes to workloads and impact on staff morale and wellbeing.                                             | Some people were more stressed because there was more work we had to do because of the virus. We had to make sure things were sterilized and disinfected more times during the day. (CNA) |
|                           |                                                                                                                                               | The acuity and the need of the patient was increased. . . It was just the demand of the job increased because the patient's needs increase. (Nurse) |
|                           |                                                                                                                                               | Out of five of the nurses, two of them quit. They never rehired any other nurses. The morale of the staff went down because . . . the administration never cared about how their workload has increased . . . so that reduced our morale here . . . The pay still remains the same. The workload has gone up. (Nurse) |
|                           |                                                                                                                                               | I would say the only time we really feel unsafe is when we're extremely understaffed which happens every other day, so. And they cut staff on top of it. (CNA) |
| Safety Conditions        | Perceptions of safety at work and stressors related to it, including access to and utilization of personal protective equipment (PPE), perceptions of safety protocols in place, and perceived risk from colleagues or patients, and thoughts on infection control policies. | I don't feel very safe because I usually interact with very many patients . . . Even though I use the PPE, I don't feel that safe . . . I don't know when I'll meet an individual who's sick. So, that really scares me. (Nurse) |
|                           |                                                                                                                                               | It was just a little scary. I just felt like we didn't have enough access to hand sanitizer, little things like that, even though it was a . . . even though it's a nursing home, I would think they would have all of that stuff readily available, but it had to take some time to actually get the dispensers up and things like that. (CNA) |

(continued)
they were working on the front lines during the pandemic. Reduced public transportation service substantially increased commute times; closures of schools and daycare facilities led to lack of childcare; and financial challenges arose as many lost other sources of income. For example, staff who had several part-time positions were prohibited from working in more than one LTC facility at a time, other family members or wage earners in their households lost their jobs, or they faced increased expenses for childcare or commuting.

**Workplace stressors**

Participants’ experiences related to workplace stressors varied significantly across facilities. Some reported positive perceptions of their facility’s management of the COVID-19 pandemic; others described poor working conditions and administrative failures seen as harmful to employees and residents. Perceived administrative support, changes in workload, and safety conditions were consistently discussed as factors that influenced staff wellbeing.

**Perceived administrative support:** Participants often linked their professional wellbeing during the 2020 COVID-19 surge to their perception of support from facility leadership. Those with more favorable or neutral views of their facility’s responses described administrators who were present during the pandemic and transparent in their communication with staff, responded quickly and seriously to the threat of the virus, provided staff with the resources and support they needed to stay safe while working, and demonstrated their appreciation for frontline staff in concrete ways (e.g., more lenient sick leave policies, financial incentives). Those with negative perceptions of their facility’s responses described the opposite — a lack of transparency and onsite presence, delayed implementation of infection prevention policies, and a lack of appreciation for employees and the stresses they faced due to the pandemic. While administrative support arose clearly as an independent subtheme in interviews, some participants also directly linked perceived administrative support to workload and safety conditions, described below.

**Workload:** Interviewees reported that workloads increased during the COVID-19 pandemic due to both staff shortages and changes in job responsibilities. Staff shortages were attributed to staff resignations due to fear of contracting COVID-19 or limits on the number of LTC facilities where they could work at the same time, a higher number of employees calling out sick due to illness or anxiety related to the pandemic, and layoffs. Job responsibilities intensified due to growing resident needs (e.g., providing complex care for those sick with COVID-19 or shortening a decline in functioning due to sedentary lifestyles, providing additional support to compensate for lack of socialization), new time-consuming cleaning protocols, and added responsibilities resulting from changes in facility policies, such as individualized meal distribution, as well as staff shortages.

**Safety conditions:** Perceptions of safety at work during the pandemic also varied among participants and contributed to anxiety and stress, especially at the beginning of the pandemic when less was known about the virus and it was spreading rapidly in LTC facilities. Most participants reported insufficient access to essential PPE during the spring 2020 surge. Participants discussed purchasing their own masks, being required to re-use materials designed for single use, and having limited access to PPE due to management locking up and rationing materials. Those who reported sufficient PPE throughout the surge attributed their access to supportive leadership.

Other safety concerns included the perception that facilities failed to effectively implement or enforce infection control policies and fear of coworkers who were less cautious about the virus in their personal lives or who were not adhering to safety protocols.

### Recommendations for Administrators

Participants offered recommendations for improvement that centered on changes at the facility level that could increase employee and resident safety, reduce employee stress, and demonstrate a greater appreciation and respect for staff. General recommendations focused on humanizing employees and demonstrating empathy for the difficulties they faced. More concrete recommendations included providing hazard pay and other employee benefits that addressed challenges in employees’ personal and professional lives (e.g., support with childcare expenses, more paid time off, mental health support).
support, an on-site place to stay overnight) and hiring more staff, which participants felt would both improve resident care and alleviate employee burnout. Participants also recommended greater transparency and improved communication with staff, as well as stocking up on supplies to avoid shortages in the future.

Discussion

This study aimed to explore the experiences of frontline staff caring for older adults in congregate LTC settings during the COVID-19 pandemic in order to inform strategies for supporting these essential frontline workers — in general and in the face of future public health emergencies.

Overall, participants reported experiencing substantial anxiety, stress, and trauma during the COVID-19 pandemic, especially during the first wave in NYC in Spring 2020. Four main themes emerged in the analysis of interviews, including 1) the toll of the virus on LTC care providers' mental and emotional wellbeing; 2) home and work-life balance stressors that were caused or exacerbated by participants’ professional roles; 3) workplace stressors that contributed to poor mental health and low staff morale; and 4) participants' recommendations for facilities and administrators to improve support for staff members in general and during a pandemic.

Other studies examining the wellbeing of health care workers in LTC facilities during the pandemic have similarly reported that they experienced increased fear, stress, burnout, physical exhaustion, shortages of PPE, concerns about infecting family members, and increased workloads. Studies examining the impact of the virus on the broader health care workforce caring for COVID-19 patients also suggest poor mental health outcomes, including high levels of insomnia, depression, anxiety, burnout, and others, compared to health care workers not caring for patients with COVID-19.

Few studies have examined the impact of stressors at home or related to work-life balance on health care workers' wellbeing during the COVID-19 pandemic. However, similar to findings from the present study, Evanoff et al. found that family and home stressors were strongly and consistently associated with mental health outcomes, and that having a supervisor supportive of family roles and commitments contributed to improved employee wellbeing. These findings, as well as a substantial body of research that demonstrates strong connections between family-supportive work environments and staff morale in general, suggest that the wellbeing of care providers in LTC facilities could be improved with policy and culture changes that provide a supportive environment and concrete resources for employees and the challenges they face in their personal lives, especially in times of crisis.

Workplace stressors described by participants have been explored more frequently in the existing literature. Findings from the present study are consistent with those reported by others during the COVID-19 pandemic, as well as previous epidemics (e.g., SARS, MERS), which have similarly suggested that increasing workloads, staff shortages, poor safety conditions, and lack of organizational support and communication contribute to poor mental health outcomes and low staff morale among frontline workers in health care settings.

Participants in this study offered concrete recommendations for facility administrators that address the issues they described in the interviews, including strategies for improving support for frontline staff (including the stressors they face at home) and addressing the workplace stressors that detract from employee wellbeing. They suggested hiring more staff to reduce workloads, improving pay and benefits, and providing more support to those struggling to balance family and professional commitments. Respondents also consistently recommended increased transparency and communication from organizational leadership.

Together, these findings suggest that despite the inevitable challenges inherent in providing care to vulnerable populations during a pandemic, concrete actions to support frontline care providers' needs — both at home and in the workplace — have the potential to improve staff morale and reduce job dissatisfaction, even during times of crisis.

Limitations and Future Research

This qualitative study is limited to the experiences of a small group (n=14) of frontline care providers in congregate LTC facilities in NYC and, as such, may not be generalizable to a broader population of care providers working in other facilities, health care settings, or geographic locations. Future research should utilize a larger sample and explore best practices and the implementation of policies designed to support frontline staff, both in the context of the COVID-19 pandemic and in general, and their impact on frontline worker morale, job satisfaction, and rate of turnover.

Additionally, since LTC frontline staff and facilities were inundated and overwhelmed by the COVID-19 pandemic and the study was time-sensitive given the desire to make the findings quickly available and useful, this work was conducted without close partners who work in LTC settings and may have — under other circumstances — offered guidance in both the design and the analysis phase. Future research on this topic should aim for closer collaboration with LTC frontline workers.

Conclusion

Findings from this study indicate that those working in LTC facilities in NYC during the COVID-19 pandemic experienced mental health challenges and difficulties in their personal or home lives as a result of their professional roles. While some of the stress and anxiety reported was unavoidable due to the severity of the pandemic and initial uncertainty related to safety and transmission, findings suggest that some negative impacts of the pandemic may have been mitigated by improved support — including the implementation of more concrete measures to support and protect staff and greater transparency and communication at the organizational level — for LTC staff providing care on the frontlines. Future policies implemented in LTC settings should consider the existing burdens and needs of frontline workers at home and in the workplace and aim to alleviate — rather than add to — the challenges they already face in their essential roles.

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Declarations of Competing Interest

None.

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