INTRODUCTION

Nationally, there have been over 643,000 coronavirus disease 2019 (COVID-19) cases among nursing home residents and more than 130,000 deaths as of March 2021. During the COVID-19 pandemic, nursing home staff, in particular frontline nursing assistants (NAs), played an essential role in the care of residents while witnessing the devastating effects of COVID-19 on vulnerable older adults. According to the United States Bureau of Labor Statistics in 2019, there were 1,579,100 NAs in the United States, with 37% working in nursing facilities and 11% in community care or assisted living facilities. NAs comprise 36% of all nursing home staff and provide personal care to nursing home residents such as bathing, toileting, dressing, eating, and mobility. On average, one NA supports 12 residents in one shift, often earning just above minimum wage. In 2020, their median annual salary was $30,830 per year.

Similar to other healthcare workers, NAs continued to care for nursing home residents while simultaneously fearing for their own and their families’ safety during the pandemic. Infection control policies regarding visitations from family and friends and cessation of group activities meant that residents were isolated and confined to their rooms, with NAs being the primary source of comfort and human contact. NAs performed this important work against a backdrop of continued uncertainty as well as unforgiving and mostly negative press coverage. To explore their experiences during the pandemic, nine NAs from four different nursing facilities in Massachusetts were interviewed. The length of their nursing home experiences ranged from only months for two assistants who started working around the pandemic, to 25+ years for those with more experience.

THEMES IDENTIFIED

Changing and challenging regulations and requirements

The 1987 Nursing Home Reform Act was initially enacted to strengthen federal regulations regarding...
quality concerns for Medicare and Medicaid participating nursing facilities8 and has since undergone policy updates to ensure other quality, administrative, and care compliance. During the COVID-19 pandemic, state regulatory agencies continuously changed policies regarding infection control and COVID-related practices as the medical and scientific communities learned more about the SARS-CoV-2 virus. These frequently changing regulations, such as those related to the use of personal protective equipment (PPE), led to frustration and confusion among frontline staff, especially NAs in nursing homes. Some NAs felt that their facilities did not take the time to listen to them or train them for proper PPE usage during the early days of the pandemic. Due to the scrutiny from state regulatory agencies, there was an enormous emphasis on appropriate PPE usage. NAs and other staff members became the subject of that close examination, and many feared being penalized if they used PPE incorrectly.

Mixed perceptions of the nursing assistant

The pandemic’s effect on the perception of the NA brought about emotional responses from those interviewed. All verbalized feeling valued by the facilities prior to the pandemic. NAs perceived that their roles extended beyond the provision of personal care and included communication of resident choices, providing comfort, and improving resident experiences.8 One said she appreciated being recognized as a healthcare hero during the pandemic, while others expressed concerns about how they were being portrayed negatively by the media. Some felt the media worked against the nursing home staff and that the portrayal “on TV was just unfair.” Some were afraid to publicly wear their badges or clothing displaying the names of where they worked, changing into street clothes before leaving the nursing homes.

Isolation and psychological stress

Another major source of stress for NAs during the pandemic was profound isolation. Prior to COVID-19, NAs in nursing homes felt a sense of belonging and togetherness with each other. With infection control–related restrictions, they felt that their sense of community at the facilities was affected due to separation from each other and residents by PPE, physical barriers, and other environmental limitations. The inability to gather for celebrations, activities, and breaks intensified this isolation as many were eating and taking breaks in solitude. These events had previously served as settings where they could share stories, personal updates, and laughter, all of which were now lost.

The constant pressures and surveillance they felt to ensure adherence to proper infection control protocols added to their psychological stress. Colleagues could potentially report each other for protocol breaches, leading to mistrust, increased anxiety, and exacerbating feelings of isolation. Some would no longer speak to other NAs when passing in the hallways and some “pushed people away.” One NA described all the COVID-19-related changes as “stripping away the sense of community” in the nursing home. The isolation and negative psychological impact were further intensified in the high-stress environment of increased mortality and morbidity due to the SARS-CoV-2 virus.

Table 1 lists examples of quotes from the interviewed NAs on the impact of working in nursing homes during the COVID-19 pandemic. These are organized according to the three specific themes identified.

RECOMMENDATION

The COVID-19 pandemic has taken a significant psychological toll on NAs, many of whom are already at risk for increased anxiety and depression due to their lower socioeconomic status, high risk of contracting COVID-19, and social isolation.9,10 Based on the interviews, there is a need to ensure that there is a consistent message from nursing facilities, local communities, and media to support the NA and promote their emotional well-being.

One recommendation is to create a mechanism to build a mutually supportive learning community, such as the AHRQ ECHO National Nursing Home COVID-19 Action Network.11 AHRQ, the Institute for Healthcare Improvement (IHI), and the University of New Mexico’s Project ECHO established the National Nursing Home COVID-19 Action Network to support and train nursing home leadership in infection control best practices. Funded by the Coronavirus Aid, Relief and Economic Security (CARES) Act, the program provided weekly sessions for 16 weeks on topics such as PPE, trauma-related care, and COVID-19 vaccination planning. In Massachusetts where we participated as facilitators in the program, we witnessed the organic formation of a learning community where nursing home leadership and staff shared best practices and provided peer support to each other.

Participation in the ECHO sessions by direct care staff, especially NAs, was at times limited due to reduced staffing levels from COVID-19 outbreaks and high positivity rates. Interviewees felt that having an organized platform where they could learn together and provide and receive support to each other would help establish a sense of community and raise the stature and well-being of NAs across institutions.
TABLE 1 Quotes from nursing assistants on impact of working in nursing homes during coronavirus disease 2019 (COVID-19) pandemic organized by themes

| Themes                                                   | Quotes                                                                                                                                                                                                 |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Changing and challenging regulations and requirements | Regulations changed so often that we barely had time to learn and adjust before there was something new.  
COVID-19 is a threat, not only from the infection, but also from getting a warning for not using PPE right.  
Information was changing, sometimes from morning to afternoon, and it made us more afraid.  
I wasn’t given enough time to absorb the policy changes.  
Every day was something different (with PPE).  
It was so hot. I would get dizzy. I had a white jumpsuit on, a mask, a gown, a face shield and gloves. I would leave and just drink and drink water to try to stay hydrated. |
| 2. Mixed perceptions of the nursing assistant            | The news (on television) had no idea what was really happening.  
It made me feel horrible, like we neglected the residents even though we were doing everything we could.  
We were trying so hard and the news reports made it look like we didn’t care.  
We did not get the respect...for the work we did to keep residents safe.  
When I went to the grocery store and people saw me in scrubs they moved away from me.  
I was on the T once and people clapped because I was an aide and went to work while others stayed home. It made me feel good. I was making my family proud even though they were scared for me. |
| 3. Isolation and psychological stress                    | We worked together for 20 years, we shared food, took breaks together...now we can’t do that anymore.  
We were being watched all the time...No one knows who to trust here anymore... some of us pushed people away and became withdrawn.  
Before COVID there was a sense of community...there was more team work, a sense of togetherness...  
During COVID we (NAs) wouldn’t say anything because now our voices didn’t seem to matter.  
I was scared about getting really sick. I was scared of losing my job if all the residents died. I was scared to bring COVID home.  
We suffered alongside the residents...we see them as family and it’s heartbreaking when we ended up losing them.  
I showed up each day because I couldn’t take a mental health day. I didn’t want to lose time or pay if I had to call out...We were not able to catch our breath at all.  
One morning, really early in the morning, my resident wasn’t feeling well. Later we found out he had COVID. Everyone was so worried for me. The others were crying but I wasn’t. I knew I had to stay and take care of him. It was just him and me then. Then more residents got sick, and I took care of them, too.  
My family didn’t want me to work. I had to work. We all needed to eat. Everyone else got to stay home and be safe. It was ok though. Someone had to do the work. |

LIMITATIONS

One limitation to a virtual learning community is access to technology. NAs may not have the financial resources or training to obtain and use the necessary technology. They will need to have compatible devices, either in the form of mobile phones or computers, and WIFI capability in order to participate. The learning environment needs to be thoughtfully developed to foster community building and provide a safe forum in which to share ideas.

Additional limitations are time and content. During the 16-week AHRQ ECHO National Nursing Home COVID-19 Action Network program, there was limited NA participation because many could not leave their tasks to attend a 90-minute session every week. This speaks to the importance of the NA to the overall operational needs of a nursing facility. Given the time constraints faced by NAs, any program tailored for them in long-term care facilities will need to limit the duration of the sessions and encourage nursing facility leadership to support their attendance. The use of asynchronous pre-recorded educational sessions could increase the reach of the program, but there needs to be concurrent real-time discussion or messaging boards to foster community
building. The content of the educational training program should also focus on topics pertinent to the NAs' roles and responsibilities in order to make it as high yield as possible.

**CONCLUSION**

There has been a significant negative impact on the mental health and well-being of nursing assistants in long-term care during the COVID-19 pandemic due to the psychological and physical isolation they experienced, which was exacerbated by external forces beyond their control. We propose the development of a virtual training and communication platform modeled after the National Nursing Home COVID-19 Action Network as a mechanism to provide needed support to them. In addition, given their pivotal role in long-term care, there needs to be better recognition of the enormous challenges they face and more support of their well-being in order to improve the quality of care for the vulnerable residents they so selflessly serve.

This work is exempt from human subjects research, and therefore, there is no federal requirement for IRB review.

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**CONFLICT OF INTEREST**

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