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## Caring for those caring for older adults



Long-term care facilities (LTCFs) have been devastated by the COVID-19 pandemic. Residents living in these facilities account for approximately 40% of deaths attributable to COVID-19 worldwide,<sup>1</sup> and those who have survived have endured social isolation, repeated invasive testing, and separation from loved ones for several months. Nursing home staff have worked through staffing shortages due to staff contracting COVID-19, particularly early on in the pandemic when personal protective equipment was scarce. Several publications<sup>2-5</sup> have used large-scale administrative data analyses to understand why some LTCFs had larger outbreaks than others; however, much of these analyses did not consider personal protective equipment or staffing shortages, both of which have been major concerns throughout the course of the pandemic.

In *The Lancet Healthy Longevity*, Laura Shallcross and colleagues<sup>6</sup> surveyed 5126 LTCFs in England to better understand the factors associated with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and outbreaks among staff and residents. The manuscript is the result of a huge effort to obtain information via telephone survey interviews with managers of LTCFs, who were already under strain because of the pandemic. The study pairs administrative data on LTCF characteristics with more granular information on individual facility practices, such as staff cohorting strategies (ie, whether staff members care for cohorts of either infected or uninfected residences without moving between cohorts) and staffing practices (eg, employment of temporary agency staff and sick pay policies), not yet investigated in large-scale administrative data research. The findings are consistent with previous reports, and highlight the importance of adequate and consistent staffing in reducing the incidence of SARS-CoV-2 infections and the size of outbreaks in LTCFs.<sup>7</sup>

The key strength of this research lies in the pairing of identified factors contributing to transmission of SARS-CoV-2 infection in LTCFs with actionable recommendations to prevent such outcomes in the future. For example, data have been emerging throughout the pandemic suggesting that staff play a key role in the spread of the virus,<sup>7</sup> and measures to incentivise and value their role are urgent, both now

and in the coming years. Shallcross and colleagues<sup>6</sup> found that the odds of SARS-CoV-2 infection were significantly lower among both residents (adjusted odds ratio 0.80 [95% CI 0.75–0.86],  $p < 0.0001$ ) and staff (0.70 [0.65–0.77],  $p < 0.0001$ ) in LTCFs that paid staff statutory sick pay compared with those that did not. Frequent (ie, on most days or every day) employment of agency nurses or carers was associated with a significantly increased odds of infection in residents (1.65 [1.56–1.74],  $p < 0.0001$ ) and staff (1.85 [1.72–1.98],  $p < 0.0001$ ), and of outbreaks in at least a third of residents and staff combined (2.42 [1.67–3.51],  $p < 0.0001$ ). Each one unit increase in the staff-to-bed ratio since baseline (March 1, 2020) was associated with a reduced odds of infection in residents (0.82 [0.78–0.87],  $p < 0.0001$ ) and staff (0.63 [0.59–0.68],  $p < 0.0001$ ). LTCFs in which staff often or always cared for both infected and uninfected residents had significantly higher odds of infection in residents (1.30 [1.23–1.37],  $p < 0.0001$ ) and staff (1.20 [1.13–1.29],  $p < 0.0001$ ) compared with those that cohorted staff with either infected or uninfected residents.

Other factors associated with a significantly increased risk of transmission in residents included an increased number of admissions to the facility and difficulties in isolating residents due to non-compliance (eg, because of dementia). Notably, despite a strong emphasis on the US Centers for Medicare and Medicaid Services' rating of LTCFs in terms of quality of care and infection prevention in the USA, the UK Care Quality Commission ratings of administrative leadership in this report showed no marked effect on the risk of introduction or transmission of the virus in LTCFs in the UK.<sup>3,5</sup>

Survey data always includes inherent limitations, such as selection or non-response bias (only 5125 [56%] of 9081 eligible facilities participated in the survey), and recall bias (ie, the data were reliant on the managers' recollection).<sup>6</sup> Nevertheless, the authors address these limitations by pairing survey responses with individual testing results available through the national testing programme, and by comparing administrative data to obtain a representative sample of LTCFs in England.

For too long we have overlooked and underpaid the staff caring for our ageing adult population. Staff in these facilities often work several jobs to earn a living

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wage, and we have seen the implications of this play out with the rapid spread of SARS-CoV-2 across LTCFs. Staff might hesitate to call in sick from work because of the risk of losing shifts and pay, resulting in potential introduction of the virus into our most susceptible population. Until we value nursing home staff and adequately educate them on infection prevention practices, this pattern will progress. As COVID-19 vaccines become available, LTCFs remain at risk. Early reports of vaccine uptake from nursing home staff in the USA have been as low as 45%; many staff cite a lack of trust in administration or government as reasons for vaccine hesitancy, suggesting an urgent need for support and dedicated education.<sup>8</sup>

The work by Shallcross and colleagues<sup>6</sup> highlights key features that can increase the risk of transmission of SARS-CoV-2 in LTCFs and offers ways to address transmission in the coming months. The pandemic has underscored a need to re-evaluate not only the way we care for older adults, but also the way we care for the staff performing these essential duties.

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