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BRIEF REPORT

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Cracks in the foundation: The experience of care aides in long-term care homes during the COVID-19 pandemic

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Abstract

Background: Care aides (certified nursing assistants, personal support workers) are the largest workforce in long-term care (LTC) homes (nursing homes). They provide as much as 90% of direct care to residents. Their health and well-being directly affect both quality of care and quality of life for residents. The aim of this study was to understand the impact of COVID-19 on care aides working in LTC homes during the first year of the pandemic.

Methods: We conducted semi-structured interviews with a convenience sample of 52 care aides from 8 LTC homes in Alberta and one in British Columbia, Canada, between January and April 2021. Nursing homes were purposively selected across: (1) ownership model and (2) COVID impact (the rate of COVID infections reported from March to December 2020). Interviews were recorded and analyzed using inductive content analysis.

Results: Care aides were mainly female (94%) and older (74% aged 40 years or older). Most spoke English as an additional language (76%), 54% worked full-time in LTC homes, and 37% worked multiple positions before "one worksite policies" were implemented. Two themes emerged from our analysis: (1) Care aides experienced mental and emotional distress from enforcing resident isolation, grief related to resident deaths, fear of contracting and spreading COVID-19, increased workload combined with staffing shortages, and rapidly changing policies. (2) Care aides' resilience was supported by their strong relationships, faith and community, and capacity to maintain positive attitudes.

Conclusions: These findings suggest significant, ongoing adverse effects for care aides in LTC homes from working through the COVID-19 pandemic. Our data demonstrate the considerable strength of this occupational group. Our results emphasize the urgent need to appropriately and meaningfully support care aides' mental health and well-being and adequately resource this workforce. We recommend improved policy guidelines and interventions.

KEYWORDS
care aides, COVID-19 pandemic, long-term care home, long-term care workers, nursing home

INTRODUCTION

Care aides provide up to 90% of direct care to residents in Canadian long-term care (LTC) homes.[1] Pre-pandemic, they were at high risk for burnout,[2] job dissatisfaction,[3] and poor mental and physical health.[4] Amplifying this, they experience systemic biases. Most are middle-aged and female (90%–95%).[1] Many are immigrants and speak English as an additional language.[1,5] Most have limited post-secondary education or formal training.[6] Pre-pandemic, more than 30% worked more than one job, largely for financial reasons.[1] Positions were often part-time without benefits.[6,7]

In 2020, during pandemic waves 1 and 2, more than 80% of total Canadian COVID-19 deaths occurred in LTC homes.[8] That fell in wave 3, with vaccination protection, but remained around 43%.[9] Previous studies of people living through crises and traumatic events indicate that we can expect significant ongoing effects of COVID-19 on LTC residents and frontline workers. Reports from SARS outbreaks[10] and early evidence from this pandemic[11,12] describe negative consequences on mental health of healthcare workers in many settings. Some reports on frontline workers signal severe, long-term effects on mental health.[13] Years after this pandemic, workers may develop acute stress disorder, depression, alcohol abuse, anxiety, insomnia, and post-traumatic stress disorder.[6,14,15] Pandemic experiences of frontline LTC workers are not well described, limiting our understanding of how pandemic conditions and public health measures affected them. Further, limited research explores how care aides cope during and after times of extreme stress.

This qualitative study aimed to understand the impact of COVID-19 on frontline LTC staff during the pandemic and to inform a large survey in late 2021.

Key points

- In long-term care, staff illnesses, additional infection prevention and control measures, and changing orders restricting visitors and enforcing isolation resulted in significantly increased workloads and less time available for care aides care for residents. COVID-19 heightened fears of transmitting the virus to residents at work and family members at home.
- Care aides experienced mental distress from enforcing severe isolation measures that resulted in resident decline; from the deaths of residents due to COVID-19; and from an overwhelming fear of contracting the virus themselves or spreading it to their families.
- Care aides used unique coping strategies including relationships with coworkers, extended family, and faith and cultural communities as consistent sources of resilience.

Why does this paper matter?

Poor quality of work life for care aides in long-term care homes pre-dates the pandemic. However, the strain on resources during the pandemic and the resulting negative effects on residents have amplified the need to ensure adequate direct care hours for resident care and to ensure adequate mental health and wellness supports for care aide, as well as supportive work environments.

METHODS

Using a qualitative-descriptive approach,[16,17] 5 trained interviewers conducted semi-structured interviews with 52 care aides (video/audio recorded). The University of Alberta Research Ethics Board (Pro00037937) approved the study.

Setting

We purposively selected 8 Alberta LTC homes and one in British Columbia, across 2 strata: ownership model (for-profit, not-for-profit) and COVID-19 intensity (high, low), calculated as cumulative number of cases above (high) or below (low) 50% of a home's total bed number (March to December 2020).

Participants

We interviewed a convenience sample of 52 care aides (January to April 2021). We used purposive sampling to invite LTC homes within our strata. Participants from the homes volunteered or were invited by the director of care or manager. Information letters were emailed before interviews. Verbal consent was recorded before interview start.

Data collection

We developed a semi-structured interview guide (Table S1) that was refined alongside interviews and concurrent analysis. Interviewers kept debriefing and methodological notes describing each interview's process and

content.[18] Interviews (30–40 min) took place in private, generally at a workplace office/room during shifts, and were recorded via telephone or video (Zoom). Participants were comfortable and willing to share their experiences. None asked to stop the interview.

Data analysis

Interviews were transcribed verbatim, cleaned, and de-identified. Each transcript was analyzed by 2 interviewers. All data were managed with Quirkos™ 2.4.2.[19] We used inductive content analysis[20] techniques. The entire qualitative team analyzed the first 10 transcripts for congruence in coding and interpretation. Concurrent data collection and analysis facilitated the refinement of interview protocols and coding frames. Twice weekly team meetings maintained common direction and resolved interpretive differences through collaborative discussion.

FINDINGS

Most care aides were female (94%), born outside Canada (91%), and spoke English as an additional language (76%) (Table 1). They were older and had worked an average of 10 years in their current role. Pre-pandemic, 56% worked in one LTC home only; 22% of those worked full-time. When government orders required care aides to work in only one home, 54% worked full-time.

Experiences described by care aides were remarkably consistent across care homes. We found no differences across sample strata (low/high COVID incidence, for-profit/not-for-profit homes).

TABLE 1 Characteristics of interview participants

Participant characteristic	Care aides ($n = 52$) (No., %)
Age, years[a]	
<30	5 (10.2)
30–39	8 (16.3)
40–49	17 (34.7)
50–59	12 (24.5)
≥60	7 (14.3)
Female	50 (94.3)
English as an additional language	40 (75.5)
Years in current role, Mean (SD)[b]	10.3 (8.0)
Number of long-term care homes worked in, pre-pandemic[c]	
1	28 (56)
2–4	22 (44)
Working full-time hours[b]	
Pre-pandemic	11 (22.0)
During pandemic	27 (54.0)
Shifts worked	
Day	24 (46.2)
Evening or night	17 (32.7)
Different shifts	11 (21.1)

[a] $n = 49$, missing 3 responses.
[b] $n = 51$, missing 1 response.
[c] $n = 50$, missing 2 responses.

Theme 1: Compounding distress

Care aides experienced severe compounding distress from witnessing the impact on residents of COVID-19 infection, increased resident deaths, and resident isolation that caused extreme loneliness and physical and cognitive deterioration. Their caring values were compromised and they had little opportunity to grieve resident deaths. Their stress and fatigue were exacerbated by staff shortages and workloads.

Custodial versus caring role

Early in the pandemic, LTC homes severely restricted movement into, out of, and within sites. Residents were isolated in their rooms with doors closed and without contact with other residents or family (Table 2, quote 1). Care aides expressed profound guilt upon observing decline in cognitive status and mental and physical health of residents from prolonged isolation and immobility. Most talked about the emotional toll of being unable to offer physical touch, comfort, and companionship. They were distressed by rushing care and limiting it to essential care only (Table 2, quote 2). Masks, goggles, and face shields severely disrupted communication; many residents could not recognize or clearly hear care providers.

Resident despondency, observable as lost interest in daily activities and motivation to eat, worsened with extended separation from family. Several care aides described residents exhibiting more frequent and severe aggressive behaviors. They described how challenging and taxing it was to continually re-explain the need for isolation to residents and why family members could not visit, while reassuring residents that families still loved them (Table 2, quote 3).

TABLE 2 Representative quotes for Theme 1-–compounding distress

Quote #	Quote from care aide	Participant #
Custodial versus caring role		
1	*[residents] tell me that they would rather die than not to be allowed out again. They feel like they are going to be stuck in here for the rest of their lives; they are not wrong some of them, so it's hard.*	HCA 006
2	*They get so lonely because they cannot see families as they used to. And before, if we saw them like that, we could just easily can give them a hug ... but now, no, you cannot touch... that was the most hurtful for me to see them so sad...*	HCA 004
3	*... it's to protect you, they did not necessarily grasp that... and even the families when they would come in and you would ask them to put on their mask...trying to explain that 17 times a day, you could tell it was wearing on some of the staff.*	HCA 030
Grieving and loss		
4	*I treated them like my grandmother or grandfather. I'm still missing them. They are not here. So that makes us totally changed.*	HCA 038
5	*And when we get to work, when we came in...she's already in a bag. It was really emotionally tough for me. I do not mind the work...it's the losing of life...I do not know how many...it was really rough.*	HCA 036
6	*We used to [after death] go close their eyes, wash them, cover them ... and with this COVID ... we were not allowed to do anything for him ... once he dies, you should not go back in the room.*	HCA 020
Fear of COVID		
7	*I do not want to risk seeing them and then they are ... [going to] get COVID from me ... I'm going to carry that for the rest of my life.*	HCA 008
8	*Sometimes I change my clothes in the garage before I enter my door ... So, I told my kids and my husband 'do not use that washroom that I'm using'. Because I am scared that I can spread to them.*	HCA 032
9	*... we got COVID upstairs on the second floor... so the first floor was like 'I do not want to see you. ... I do not want you to even say hello to me' because they were so scared.*	HCA 047
Staffing shortages		
10	*We need more staff at night. ... If they give us more staff, you have the opportunity to wash them to spend more time with them ...now three to five minutes a resident ... we have a time limit*	HCA 050
11	*No time...not like we used to do for the residents... We did not do anything extra, we used to do one on one with them...sometimes we would sit with them, talk...but we cannot do that now.*	HCA 022
Communication		
12	*There needs to be more consistency...we will have one nurse say to us 'nope do not worry about that' And then the next night the nurse says 'no, no, no.'*	HCA 028
13	*Just memos ... we were just wearing the mask. And all of a sudden it comes back to safety goggles. Then the day staff they tell us 'no, no, that was from THREE days ago!'*	HCA 041
One worksite policy		
14	*I lost one job because of the one site policy, that's a big impact on the financial aspect. Because I'm a single Mom with two teenagers.*	HCA 004
15	*I still have six brothers in Philippines ... I'm the only one helping them. ... I have to work so I can send them help, like money-I can support them ...Nobody can help them except me*	HCA 001
16	*I do not want to leave the people who already need me to go to people who are not in an emergency right now...that's how I come to stay [at this care home].*	HCA 021

Grieving and loss

Unprecedented, untimely resident deaths from COVID-19 upset care aides who had long-term relationships with residents and families. Care aides reported feeling like they had lost their own parent or grandparent. Returning to work each day became difficult as they wondered if residents would still be there (Table 2, quotes 4 and 5). This was worsened by truncated end-of-life and post-mortem rituals without family presence (Table 2, quote 6). Care aides rarely used terms such as depression, anxiety, loss, or grief. Even while recounting traumatic experiences, when asked directly about how they were managing they responded "I'm ok" or "I'm fine."

Fear of COVID

All care aides expressed fear, anxiety, and uncertainty when COVID-19 spread rapidly through LTC homes. They described overwhelming fear of transmitting COVID-19 to residents or their own families (Table 2, quote 7) and elaborate routines to prevent transmission to their families, such as changing clothes in their garage and staying away from family members (Table 2, quote 8). Some aides reported community stigma for working in LTC homes, especially homes with outbreaks. Some who worked in infected homes avoided coworkers and community members (Table 2, quote 9).

Staffing shortages

Without exception, care aides noted severe staffing shortages as their greatest challenge, from staff illnesses, isolation policies, or fearful staff not reporting to work. The staff pool was depleted quickly with one worksite policies.[21] Care aides worked extended hours, double and multiple consecutive shifts.

Staffing shortages dramatically decreased time with residents (Table 2, quotes 10 and 11). Care aides said residents might not be bathed for weeks during outbreaks. Aides had minimal time for oral care, hair, nails, or essential human connection such as touch and hugging.

Communication

Care aides said they rarely saw or spoke to managers directly and were not consulted on resident care planning, despite their intimate knowledge of resident preferences and needs. Normal communication chains broke, with care aides reporting being the last to know of many policy changes, especially aides on evening/night shifts. They reported receiving information about changing care processes less frequently than regulated colleagues, often second-or third-hand. Practice and policy changes were often conveyed by mass emails, causing confusion and uncertainty (Table 2, quotes 12 and 13).

One worksite policies

Pandemic policies required aides to work in only one LTC home to decrease infection transmission. Pre-pandemic, ~30% of care aides held multiple part-time positions at multiple LTC homes.[22] Under one worksite policies and other factors such as seniority and outbreak status, half the aides in our sample were reduced to

TABLE 3 Representative quotes for Theme 2-Endurance, resilience and optimism

Quote #	Quote from care aide	Participant #
1	*The residents ... they feel depressed ... deteriorating they are. The mood has changed. And you are going your best. You are doing your best to help them. And sometimes we are short on staff. And we need help. And they [the residents] are frustrating. The demand level is high. But you go there and you meet their needs but they still do not accept reality ... The resident needs help from you and you are trying your best ... you want to sit down and cry ... We need support, we need more help ... and moral support actually.*	HCA 015
Strength in connections		
2	*We talk on the phone when we can. And with our church members we always go with the Zoom meeting–every evening we have some prayer meetings or church...*	HCA 014
3	*We help and support each other... we just say-pray, we just pray. Nothing will affect us.*	HCA 015
4	*We take care our ourselves, we take care of each other.*	HCA 022
Optimism		
5	*Trying to keep positive thoughts and then this thinking one day we'll all get better and then things will be normal.*	HCA 002
6	*I can spend time with my family...I am a very family-oriented person. My husband will be home. Sometimes he cooks for me. Sometimes I cook for him.*	HCA 013
7	*It [the pandemic] helped my relationship with my children ... I got closer to my kids; they see me after work.*	HCA 004
8	*I butted heads with some people when I first got here. But it's much easier now. We all kind of understand each other and appreciate each other more, I think.*	HCA 006
9	*Honestly, the home time, the ability to regroup and really think about what is important in our life... just slowing down has been nice.*	HCA 027

part-time hours (Table 1), with significant wage losses and difficulty supporting immediate and extended families (Table 2, quotes 14 and 15). Care aides' choice of LTC home to work in was not usually based on wages, but on care aides' assessment of homes' culture, quality of teamwork, and greatest need (Table 2, quote 16).

Theme 2: Resilience and optimism

Despite compounding pressures, care aides sustained resilience and optimism. Strong relationships within LTC homes and their social networks, their compassion and acceptance, and sometimes their faith communities, were instrumental in sustaining hope and positive perspectives. Despite pressures and demands, care aides strived to meet the needs of residents, asking for moral support to help them (Table 3, quote 1).

Strength in connection

Care aides consistently expressed connection to extended family, coworkers, and cultural and faith communities (Table 3, quote 2). They relied on each other to discuss feelings and bring humor into their work. They described this connection as 'family,' with shared fears and experiences bringing them closer (Table 3, quotes 3 and 4).

Optimism

Care aides tried to maintain positive attitudes, accepting current circumstances as transient and remaining hopeful for the pandemic's end (Table 3, quote 5). Many saw no positive pandemic aspects, but some reported becoming closer to friends and family (Table 3, quotes 6 and 7). They had more time to spend with others and were less exhausted working in only one home. Others cited better teamwork and trust, with more time to reflect (Table 3, quotes 8 and 9).

DISCUSSION

This study offers a poignant picture of care aide experience in LTC during the COVID-19 pandemic. Of previous qualitative studies that interviewed healthcare workers, only 3 report exclusively on care aides in LTC homes,[23–25] with smaller participant numbers. Vermeerbergen et al.[24] ($n = 1$) reported themes of early pandemic concerns in a case study of resident isolation, overwork, and family-life struggles. Lightman and colleagues[23] ($n = 25$), reporting the impact on immigrant women as social and economic exclusion and workplace precarity. Scheffler et al.[25] ($n = 9$) reported themes of changing regulations and requirements, perceptions of care aide roles, and psychological distress. Although reporting similar themes, our study offers a more thorough and comprehensive view with its unambiguous focus on the experiences of care aides and our larger sample size.

Previous studies with care aides outline pandemic hardships,[23–25] but not coping mechanisms. We uniquely identified that care aides used coping strategies such as spirituality, peer support, and teamwork. We also identified collective strength of care aides, bolstered by relationships with colleagues, family, and their faith communities, despite difficult circumstances. These coping strategies may be unique to care aides, highlighting their distinct needs.

Limitations of this study include interview brevity to accommodate staff workload, and low sampling of males due to their low representation in the care aide population. Extrapolation to other contexts should be done with caution.

Implications

Care experiences of residents are interwoven with the experience of staff.[26] If decision-makers do not adequately remunerate and support frontline workers, quality of care and life of vulnerable residents in LTC homes is jeopardized.[6,27] Foremost, care aide stress and burnout must be offset by implementing appropriate staffing ratios and staffing mix, to reduce potential harm, and improve quality of care for residents.[27,28] Next, improved workforce experience needs concerted focus,[26] including mental health supports, proper remuneration, full-time hours, positive and valued leadership, and interventions to improve the work environment.

Even pre-pandemic, care aides experienced high burnout, mental and physical distress, and job dissatisfaction.[6] The pandemic exacerbated the needs of a workforce already overburdened and under significant duress. Frameworks such as the Institute for Healthcare Improvement's[29] "Joy in Work" offer guidance to healthcare administrators on cultivating a healthy, productive workforce. Promising practice documents are emerging to inform resiliency strategies.[30] Our results highlight possible areas of focus for both policy and work environment improvement in resilience programming for staff.

Conclusion

LTC homes continue to be greatly affected by COVID-19. Care aides experienced significant hardships mentally,

emotionally, physically, socially, and economically. However resilient they are, they require adequate support going forward. At minimum, this must include adequate staffing levels and resources, pandemic preparedness, and mental health supports. Strategies to support these essential workers must consider their cultural diversity and be developed in partnership with them. Future research should include in-depth longitudinal studies of the experiences of care aides, their needs, and efficacy of supports.

AUTHOR CONTRIBUTIONS

Carole A Estabrooks conceived of the study idea. Carole A Estabrooks and Jude Spiers designed the study. Heather K Titley, Sandra Young, Amber Savage, Trina Thorne, and Jude Spiers contributed to the data collection, analysis, and interpretation of data. Heather K Titley led manuscript preparation. All authors contributed substantially to drafting and revising this manuscript.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

SPONSOR'S ROLE

The sponsors had no role in the study design or interpretation of the data.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

Table S1. Interview guide and suggested questions for care aides.

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