In Their Own Words: The Challenges Experienced by Certified Nursing Assistants and Administrators During the COVID-19 Pandemic

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Abstract

This qualitative study aimed to provide an in-depth understanding of the challenges experienced by certified nursing assistants and administrators during the unprecedented COVID-19 crisis. We conducted 6 administrator interviews and 10 remote focus groups with day and evening CNAs at 5 nursing homes ($N = 56$) in downstate New York. Content analysis was conducted, and emerging themes were identified across sites and roles. Results showed numerous challenges for both CNAs and administrators including many that were personal. These personal challenges included feeling helpless, anxious, or fearful; experience of COVID illness; and balancing high concurrent demands of work and family. There were also many operational challenges such as a lack of COVID testing capacity, information, and consistent guidance and support, staffing and equipment. Understanding these challenges can facilitate goals to promote future safety, skill refinement, and enhanced resilience in the workforce.

Introduction

Certified nursing assistants (CNAs) have a critically important job. They care for our most frail and vulnerable older adults, nursing home residents. Due to the nature of this job, CNAs often experience repeated exposure to serious illness, suffering, and death of residents, many of whom they have become close to over time (Barooah et al., 2015; Cagle, Unroe, Bunting et al., 2017). Yet, CNAs are among the most undercompensated, least trained, and undervalued workers in the United States (Bowers et al., 2003). Poor working conditions include emotionally and physically demanding workloads; staff shortages; and lack of job growth possibilities which can affect emotional well-being, personal health, and the ability to provide appropriate care (Austin et al., 2009). These daily challenges may also lead to issues with retention of CNAs (Dill et al., 2013; Stearns & D'arcy, 2008). The latter has a negative, rippling effect from CNAs, to residents, to long-term care facilities. Though they would greatly benefit from supportive interventions, CNAs represent the professional caregiver group that is least likely to receive interventions that address compassion, work-life balance, and self-care (Sacco et al., 2015).

Notably, the coronavirus disease 2019 (COVID-19; hereafter referred to as COVID) has greatly magnified the "value and precarity" of the long-term care system and its work force in the U.S. (Scales, 2021, p.497). Direct care staff already facing health and financial risks including low wages and limited resources to support themselves and their families, have had these challenges worsened by COVID (Almeida et al., 2020). CNAs also face resulting stress and burn-out due to COVID (Blanco-Donoso et al., 2020). Combined with the advanced age, frailty, and chronic co-morbidities typically experienced by nursing home residents, there have been high rates of severe illness and death in nursing homes due to COVID. It is not surprising that nursing homes have been called "ground zero" (Barnett & Grabowski, 2020) and the "Titanic of cruise ships" (Crotty et al., 2020) with regard to the COVID pandemic. Of all staff, CNAs spend the most time with and provide the most personal care to residents compared to other care providers (Pennington et al., 2003). Research on obtaining more detailed information directly from CNAs who experienced the pandemic is needed to gain greater understanding of the scope of change needed to support these workers in the future.

In addition to exploring the experiences of CNAs, it is important to hear about the pandemic hardships of nursing home administrators. While direct care staff are the backbone of care for nursing home residents, administrators must

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manage the operational functioning of the facility, and the challenges they face ultimately affect frontline staff. These leaders are responsible for the quality and safety processes in the nursing home which then influence the performance of the workforce, job satisfaction, and staff retention (Siegel & Young, 2021). Nursing home administrators have one of the most challenging leadership jobs in health care often with high turnover rates (Castle et al., 2007). They face a complex regulatory environment, vulnerable residents, a workforce challenged with high turnover, and uncertain revenue streams (Myers et al., 2016). Research on the specific challenges identified by administrators during the pandemic will further our understanding of how they operated to address these crises during the pandemic (Siegel & Young, 2021). To date, research on the experiences of nursing home leaders and staff during COVID has primarily been survey-based. We sought to explore the lived experiences of CNAs and administrators to gain a broader, more nuanced understanding of the greatest challenges they faced during the COVID pandemic in order to inform efforts to promote future resilience for nursing home staff.

Methods

Recruitment and Data Collection

We conducted a series of focus groups and interviews exploring workers' and administrators' perceptions of (1) the greatest challenges presented by COVID, (2) how CNAs and administrators adapted to these challenges, and (3) what resources were most needed to support the workforce, facility and residents. Open-ended questions allowed us to identify other unexpected issues and emerging themes of importance to CNAs and administrators. This analysis focused specifically on the challenges identified by CNAs and administrators posed by this novel, stressful experience to inform future supports for the workforce. Findings on adaptations and needed resources were reported separately (Franzosa et al., in press).

We recruited participants through purposeful sampling. Our study was part of a larger evaluation of a workforce training center created through a long-term care workforce training initiative of the New York State Department of Health. Our partners at the training center identified nursing homes in different geographic areas covering each of the five NYC boroughs, Westchester and Long Island, as COVID-19 case rates varied widely across the metro region. To minimize variation in our sample, we focused on nursing homes that were non-profit, and those with direct care staff who were unionized, as the majority of nursing homes in the metro New York area have at least one union bargaining unit. While we did not assess management practices, nursing homes that are proprietary or without unionized staff may differ substantially from non-profits. Our study team contacted administrators at nine sites to request participation,

which included an administrator interview and two CNA focus groups (including both day and evening shifts). Six sites agreed to participate, although one site was ultimately unable to schedule focus groups due to rising cases of COVID in the community and only participated in the administrator interview. Administrator interviews were held by telephone. Focus groups were held in-person at the facility in a space that allowed appropriate distancing with the moderator facilitating remotely by video due to limitations on visitors. A staff representative at each site recruited focus group participants and obtained written consent. They announced the project at staff meetings, and CNAs who voiced interest and filled out a consent form were included in the focus groups. Each participant received a $25 gift card as an incentive. Administrators were not informed regarding who participated in the focus groups.

We conducted a 30–45 minute phone interview with each administrator, and 45-minute focus groups with CNAs, including a group each of day and evening shift workers at each facility, with four to six participants per group. CNAs also filled out a 10-item questionnaire related to demographic information, work experience, and experience with COVID. The interview and focus group guides were developed collaboratively by the study team based on their expertise in nursing home and workforce research, existing literature, and newly available data on nursing homes' COVID experience. The focus group format was piloted with a group of non-CNA employees at one of the participating sites for length and clarity, as well as to identify any technical issues arising from remote moderation. The focus group guide centered on our three core areas of inquiry (challenges, adaptations, and recommendations). Core questions around workers' challenges included: In terms of your work over the past 6 months, what has been the most challenging? How have you managed these challenges? Who helped you manage these challenges? What do you worry about most going forward? We also asked how they adapted to the challenges and what resources were needed to support them in the future.

To effectively facilitate the groups remotely, and to meet best practices of convening smaller groups when researching potentially sensitive topics (Finch & Lewis, 2003), we limited the group size to ensure all CNAs would have the opportunity to participate and stay engaged. Focus groups were kept to 45 minutes to enable us to hold them during release time on workers' usual shifts, and to avoid taking workers off their units for longer than necessary during a time when many facilities were already short-staffed. Given the challenging issues discussed, the moderator acknowledged and left space for CNAs' emotional responses while also guiding them towards describing specific impacts and facts (for instance, asking clarifying questions about tasks or policies), and probing contrasting experiences and perceptions within the group. For administrators, similar questions were asked, along with additional questions regarding what support they offered workers. Focus groups and interviews were audio

recorded with participant permission and transcribed verbatim. All data collection occurred in October and November, 2020. This study was approved by the Institutional Review Board at the study site. The "Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist" is included as a Supplemental material.

Data Analysis

Our analysis of the interviews and focus groups employed a combined deductive and inductive approach. We drew from directed content analysis, identifying a priori codes based on key project questions (challenges due to COVID, strategies to manage challenges, and recommendations/resources needed in the future), and also incorporated open codes based on emerging ideas and concerns (Hsieh & Shannon, 2005). Study team members independently reviewed transcripts for two administrator interviews and two focus groups, noting key themes, issues, debates, and questions, and met to compare findings and develop an initial codebook. Each additional interview and focus group transcript was coded by one team member and reviewed by a second, with the full team meeting weekly to continue discussing and refining codes and subcodes. We also explored variation within and between CNA groups, and between CNA and administrator perspectives. The team then met to probe and clarify emerging themes, maintaining rigor via in-depth writing and discussion of key findings, reviewing the accuracy of code definitions and their appropriate application against our analytic memos, and recoding segments as necessary (Lincoln & Guba, 1986). CNA and administrator interviews were first analyzed separately and then compared and contrasted to highlight emergent themes and divergent perspectives (Kendall et al., 2010). Data were managed in Dedoose 12.5. Quotations and supporting data from all participating nursing homes are presented in the results, but are not tied to specific sites to maintain confidentiality.

Findings

Site Characteristics. Our recruitment efforts coincided with the beginning of the second NYC COVID surge in fall 2020, requiring us to be more flexible in our sampling as nursing homes struggled to manage rising COVID rates. Our six sites were large-sized with an average of 422 beds compared to the average of 288 beds in the New York metro area. The facilities were all non-profit, and all but one was unionized. Sites were located in four out of five New York City boroughs (Queens, Staten Island, the Bronx, and Manhattan) and Nassau and Westchester counties. Based on a report by the New York State Department of Health on COVID-related deaths in nursing homes (data updated through February 4th, 2021), these six sites collectively experienced a total of 311 COVID resident deaths, or approximately 12 deaths per 100 residents. The nursing homes are each largely financed via government funding (through public Medicare and Medicaid programs) with some beds paid via private pay. Nursing homes were also individually responsible for attaining and covering the cost of the supplies they utilize including personal protective equipment (PPE).

Sample Characteristics

Fifty-six CNAs in total participated in 10 focus groups at five sites (group size ranged from 5–6). The majority of CNAs were female ($n = 53$, 95%), Black ($n = 45$, 80%), and between the ages of 40 and 59 ($n = 33$, 59%). Thirty-three (59%) participants had worked as CNAs for over 10 years and twenty-nine (52%) had worked at their current location for over 10 years. Over three quarters of CNAs (79%) reported having worked with a resident who "had or may have had COVID" with another 11% stating they were unsure if they had worked with a resident with COVID. Additionally, 14 (25%) CNAs reported that they themselves had COVID and six (11%) indicated they were "unsure" whether they had experienced COVID. The six administrators had a median of 8 years tenure at the facility (Range = 1–35), and a median of 6.5 years in their leadership role (Range = 1–12 years).

Certified Nursing Assistants' Challenges

Our results showed that CNAs faced a myriad of personal challenges such as feeling stressed and balancing high concurrent demands of work and family. There were also operational challenges including inconsistent guidance and support and inadequate staffing and equipment.

Personal challenges for CNAs included feelings of fear and anxiety, high levels of work-related stress and helplessness caused by witnessing the suffering of residents, and both the volume and speed of resident death. CNAs also expressed fear of the COVID virus, including fear of infecting others (coworkers, residents or their families) or becoming infected themselves. One CNA described the chaos of the early pandemic in her nursing home as a "war zone" where she didn't "know if I'm coming back." Another shared the emotional toll the pandemic had taken:

> "I was having panic attacks at work and I was just crying. I just didn't want to come. I was scared to take the bus or the train. It was a lot emotionally."

Participants also described a sense of helplessness as they were unable to help sick or dying residents, or have the information needed to keep themselves or residents safe. As one CNA explained,

> "My biggest challenge is when I see a resident is dying, and I can't help. And then, a few days after, they are gone. So you have

to live with that, Did I do the right thing? Could I do more or what?"

Another participant described her sadness over trying to provide adequate end-of-life care to isolated residents:

"[They] are dying alone basically, now all they have is us and you know we tried to be at the bed as best as we can to just be there, make them comfortable…I get emotional about it because, you know, they're just by themselves."

Personal challenges also included the fear, discomfort and disruption of becoming ill with COVID themselves, and potentially infecting family members. Many CNAs described their COVID symptoms, getting sick and then returning to work, and the psychological toll and caregiving challenges of witnessing the sickness or death of some family members. In these instances, some CNAs noted they "had to be tough….to put on that armor" in order to continue working. This was often compounded by the challenge of managing concurrent demands of balancing a demanding work and home life. CNAs with school-aged children in particular were challenged to balance job responsibilities with overseeing remote schooling. One CNA shared that she would use her break time to check on her daughter:

"It's very hard with homeschooling and working. When I get break, call my daughter to see what she's going through at home, if she's doing what she's supposed to be doing online. When I leave here at three, I have to go home and help her with homework…catch up with the Zoom stuff that she did in classwork. So, it's like you leave from one work to another work."

Operational challenges reported by CNAs included a lack of equipment and information, and staffing issues. This was especially true at the beginning of the spring 2020 surge, and CNAs reported that these challenges affected their abilities to perform their jobs and feel safe at work. The critical lack of PPE at the beginning of the surge was particularly stressful and frightening, and several participants suggested that CNAs were not prioritized for PPE. CNAs also reported that they did not always feel supported by leadership.

The lack of and conflicting nature of information was also problematic. CNAs reported not having the knowledge they needed about the disease itself, or how to prevent and treat it. At the same time, information changed rapidly and new guidance was often in conflict with protocols that might have been implemented just a short while earlier. One CNA described her frustration at trying to meet these new protocols without adequate information, explaining that

"When the pandemic hit, one day you come to work, you work this way and the next day it was different. For example, you come in and they say, if somebody is positive with COVID, the nurses are supposed to go in and do the inspection; and the next day you come in, they said no, the nurses are not going, the CNA is going to go in, but then we didn't know how to care for them, we didn't know nothing."

CNAs also described the complex effects of staff shortages, which were critically magnified during the pandemic. Shortages were ubiquitous and associated with numerous factors including staff becoming sick and having to quarantine, fear of contracting COVID at work, and call-outs due to the exhaustion of working overtime to compensate for missing staff. As one CNA explained, "some people got sick, they have trauma. They cannot come back until they are okay. Some get fear and they take off, leave without saying. Because they are so afraid, they don't want to come to work." While CNAs were understanding about the challenges their coworkers faced, they also acknowledged it created an untenable workload for those remaining.

Staffing shortages were also intertwined with challenges around infection prevention. Additionally, CNAs noted that while some facilities grouped residents to COVID or non-COVID units, any reduction in COVID spread was likely undone by floating or "piggybacking" staff across different units because "they have to place you where you are needed." "My concern is that they keep using the same staff that's taking care of the sick patient and send them to the different units," shared one CNA. "This is not appropriate. They are supposed to hire more people…[otherwise] a lot of people get sick."

Further, while most facilities hired agency staff to fill gaps, some CNAs felt agency workers were unfamiliar with the facility's residents, policies and protocols. CNAs in several groups also felt that agency staff were not dependable, noting that "they're not responsible…they come when they want to and you can't rely on them." Finally, CNAs reported that short staffing compounded their intensified workload as residents required more individualized care to maintain distancing protocols. One CNA described challenge of providing individual rather than congregate meals to residents in the face of severe staff shortages, saying, "we're overwhelmed, helpless…the resident hasn't gotten fed yet…it's not like we're not doing it, but you have 40 residents and 2 [CNAs helping them to eat]." CNAs in some groups were frustrated that leadership did not recognize the toll this increased workload was taking on their ability to provide care. "You should give the best care you can," said one CNA "but at the same time…it's just more work added onto you and you're expected to still do your work the way you're supposed to be doing it."

Nursing Home Administrators' Challenges

Administrators also reported numerous personal and operational challenges that echoed the CNAs' experience, particularly around managing shortages of staff and PPE and

rapidly changing protocols. Due to their leadership roles, administrators were responsible for supporting staff needs amid constantly evolving and often conflicting government guidance. Participants described challenges regarding the provision and maintenance of transparent leadership and communication, and flexible operational and staffing strategies that allowed them to rapidly adapt to the changing environment.

Like CNAs, administrators faced personal challenges as they dealt with the trauma of resident and staff illness and death, and pointed to the stress of moral conflict. While they emphasized the need to help staff manage their fears and the emotional toll of the pandemic, many administrators also recognized how difficult it was to achieve this balance given the severity of the crisis. They readily acknowledged that the pandemic had been traumatic for both staff and management. This was true regardless of factors that differentiate staff persons in a nursing home such as whether or not they are part of a union, or their professional level such as frontline staff who provide direct care to residents, management staff, or corporate staff. As one administrator explained,

"We were all experiencing something which none of us had ever seen before. And I don't think any of us will ever be the same."

Administrator's operational challenges largely focused on staffing shortages. Staff who were on site were often asked to work overtime, which could add to their own exhaustion, and was more costly for the nursing home. But as one administrator explained "you did whatever you could to staff the units." At the same time, the loss of volunteers who ordinarily helped support operations was felt harshly. COVID protocols also demanded more personalized care for each resident and more steps for infection control which added to already full staff workloads. These shortages forced administrators to make tough choices to maintain resident care, and to choose between physical and emotional care. One nursing home had stopped admitting patients "because we didn't have the staff to take care of them…we were not going to accept more patients into a mix where we couldn't even handle what we had." Recruiting new staff during a national shortage when "everybody's competing for the same person" proved challenging. Most facilities described contracting for costly agency workers for premium payments. While several facilities tried to draw from the state volunteer pool, they expressed concern that the skills available did not always match needs, and that using retired volunteers who had not practiced in years was not "practical or safe." In some cases, facilities were able to turn to affiliated health systems or corporate offices for help contracting with agencies and managing the onboarding and orientation process.

Administrators also struggled to manage facilities and staff in an uncertain environment with few resources, describing the initial pandemic surge as an "orientation by fire" as they struggled with constantly developing knowledge and guidance, as well as shortages of COVID tests, PPE, and staff. One administrator stated that the experience was surreal, like being in an action movie:

"We were making deals. We had planes coming in from China, from Russia…and the planes would get diverted, and people would take our PPE…you would have enough PPE for tomorrow. But if that plane didn't arrive, you wouldn't have enough for Thursday."

Because of these limited resources, some administrators expressed conflict over having to operate against their own best practices to maintain care as best they could. One administrator relayed how the director of infection control for the facility's affiliated health system was "horrified by his own recommendation" to re-use PPE. "But that's what we were doing, because that's what we had," the administrator noted.

Another primary concern related to staffing and equipment costs was financial viability. Most administrators felt they could now handle the operational aspects of COVID (testing, infection prevention, treatment). However, the cost of medical supplies, equipment, and agency staff, combined with the low census following a moratorium on hospital transfers made many administrators anxious about the financial future. The poor public perception of nursing homes and lack of state or federal financial support added to this burden. "N95 [respirator masks] used to cost 80 cents and now it's $5," one administrator noted in frustration. "Where's this money coming from?" Administrators also worried that the costs of ongoing infection prevention requirements alongside a lack of government support might require them to lay off staff in the future. One administrator described the perfect storm of factors driving these challenges and his feeling of helplessness in resolving them:

"Between the [state] Executive Order barring COVID positive patients coming in here, the public perception… and then the hospitals are still not really back to where they were volume wise. So those three factors all contributing to low census, low census directly contributes to financial hardship for places like this, and that's the biggest concern going forward right now. And I don't know how to mitigate it."

Finally, all administrators expressed frustration with conflicting federal, state and local guidance. They experienced increased reporting requirements and inspections, conflicting regulatory guidance, and a lack of coordination between levels of government, creating additional or duplicate administrative burdens. Interestingly, this directly echoed the frustrations of the CNAs with administrative directives yet this was at the governmental level. As one administrator shared, "when you hear different things from the mayor, different things from the Governor, different things from CDC and different things from the nurse, you

really don't know who to listen to." This conflicting guidance also generated a climate of distrust. Some administrators viewed government officials as more interested in politics and the appearance of addressing the nursing home crisis than problem solving, with one explaining in frustration:

> "The Department of Health is changing the rules on us…and then literally citing us for things where they changed the rules. It creates a lack of trust in the regulators and governmental agencies."

Discussion

This study was able to explore the challenges experienced by nursing home CNAs and administrators during the COVID-19 pandemic. It shows that the experience of the COVID pandemic was traumatic as nursing home staff felt they were largely on their own to manage COVID-related challenges. CNAs and administrators faced complex challenges both on and off the job especially at the outset of the pandemic, driven largely by the scope of the emergency and the lack of a coordinated governmental response to the unprecedented crisis. The pandemic was a novel experience requiring extensive adjustments. Challenges were both personal and organizational in nature for both groups.

Personal challenges have resulted in ongoing needs for support for emotional health, assisting both direct care staff and administrators who dealt with the trauma of nursing home residents' deaths and their own personal trauma of being ill and/or experiencing their coworkers and family members becoming ill. For CNAs in particular, losing residents can be like losing their family members given the close relationships that they build (Marshall et al., 2017). The need to also provide support for work-life balance has become even clearer as CNAs have juggled their personal and family needs alongside their physically and emotionally demanding work.

Organizational challenges emphasized the need for structural supports for workers and nursing homes including reliable disaster preparedness efforts such as connections to supply chains for PPE. Another organizational challenge identified was the need for coordinated federal, state, and city response with clear communications. The rapidly changing and conflicting guidance and multiple, redundant surveys frustrated both staff and administrators, putting a large burden on them as they needed all-hands-on-deck just to manage the crisis in front of them. In a parallel experience, CNAs were in need of support and transparency from administrators, while administrators needed the same in terms of authoritative guidance from government. Having clear communications channels and procedures set up for all levels of staff will be essential for making progress in this area. Administrators also stressed the great financial strain caused by the pandemic and the need for continued support for nursing home operations including staffing and equipment. Given these financial

stresses, the very survival of the nursing home has been called into question (Gadbois et al., 2021).

The types of challenges we found added significant burden to an already strained and vulnerable workforce and thus, they may contribute to increased burn-out, turnover, and staff shortages in the long term (White et al., 2021). Emerging data also suggest that direct care workers who faced more challenges and experienced higher pandemic-related stress were more likely to resign from their direct care job (Cimarolli & Bryant, 2021), heightening existing workforce shortages. Outdated staffing levels have remained fixed while the needs of nursing home residents have grown with their increasing age, number of comorbidities, medical complexity, and now the challenges of COVID compared to 50 years ago when the infrastructure of the NH system was built (Laxton et al., 2020). Long-term care experts have spelled out clearly how direct care staff in the nursing home must be supported, which has been made all too clear after this pandemic. For example, staff needs include clear direction and guidance, clinical practices that protect both staff and residents, human resource policies that address emotional health, and stress management (McGilton et al., 2020). Administrators also need training and support to enhance their capacity to promote improved structures and processes with resulting outcomes in the nursing home (Siegel & Young, 2021).

Our study had significant strengths and some limitations. We were able to recruit and engage nursing home staff during a challenging time for research within the nursing homes, allowing us to capture CNA and administrator experiences in real time. Our sample represented large, non-profit, primarily unionized facilities, in the hard-hit NYC metropolitan area, and may not reflect the experiences of smaller or non-urban nursing homes. We were, however, able to capture challenging personal experiences that provide critical information on how to improve the lives of the nursing home workforce which will ultimately improve the lives of the residents they serve.

Conclusion

Some positive lessons can be gleaned from study findings. The pandemic has created new appreciation for the roles and importance of CNAs in direct care, leading to calls for and opportunities to improve these jobs. The work needed to promote future safety, skill refinement, and enhanced resilience in the workforce is now more clearly defined. Future strategies must focus on building infrastructure, communication, and teamwork among nursing home leadership and all staff. Research shows that both empowerment and better wages are necessary to retain CNAs in the nursing home (Kennedy et al., 2021). Establishing these features in nursing home practice will ensure the preparation, resources, and infrastructure to adapt quickly to future crises should they arise. Rather than return to "business as usual," the experiences of these CNAs and administrators

can serve as a template for proactively building a stronger and more resilient industry and workforce in the future. We now have a cohort of CNAs and administrators who endured this traumatic experience. Their knowledge can be used to guide others in the nursing home workforce (e.g., Burack et al., 2021). The pandemic has placed a magnifying glass on the shortcomings in the nursing home industry and its regulatory processes which are desperately in need of reform. The first-hand insight gained from the CNAs and administrators in this study can be used in future planning to prevent or mitigate similar situations from happening in the future.

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Supplemental Material

Supplemental material for this article is available online.

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