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The Challenge of Burnout in Nursing Home Care Workers During COVID-19

Addressing the concerns of nursing home staff remains a large concern for both the leaders of the industry and the residents that the staff take care of. In order to rebound from the COVID crisis the workers need to be cared for as well.

Written by: Conor O'Flynn

5/29/20

Any business owner knows that his or her company is only as good as the staff members he or she employs. You can have all of the strategies and competence on your side, but those working under you are the ones who keep the machine running smoothly. If they're functioning well, then you're going to have a better working day and week. If they're not exactly feeling 100%, then things might dither a little.

In many different fields, employees can suffer burnout. Burnout is a state of complete and utter exhaustion due to the work that has been undertaken. You've probably experienced this kind of thing before as you've probably worked your backside off to the point where you can no longer function appropriately. It's very common in nursing home staff and care workers as the labor can be very taxing on someone's mental health and physicality.

Burnout during COVID-19

We are all aware of the devastating impact the COVID-19 pandemic is having on all aspects of life. Medical personnel are feeling the brunt of this battle and yet are called upon to continue working with high energy levels, and with smiles on their faces. In particular, the staff of your nursing home are battling burnout, perhaps more seriously than the staff of other medical institutions.

Why is this?

Continued on next page…

Nobody is going home

Whether the coronavirus is managed in-house by your staff, or residents are hospitalized for a time, the bottom line is that those patients who fortunately do recover will return to or remain in the nursing home, and require more help and care than they require under normal circumstances. The virus leaves survivors in a tremendously weakened state. Your staff members are also called upon to play the roles of family members who are not permitted to visit because of the vulnerability of their elders.

Emotionally and physically draining

Your nurses, nursing assistants and direct care staff are exhausted. No matter how strong they are physically, any person will start to feel a tremendous strain when overworked. Their work is typically challenging during the best of times, but they entered this field because they can cope with it. Now, they are beset by new tasks on top of everything else they need to do. If your nursing home has coronavirus room, just the constant changing in and out of personal protective gear is enough to drain a normally energetic nurse or attendant of his or her strength.

Emotionally, aside from the legitimate worry about their own health, as well as the impact on their families, your staff members may be fighting depression over the decline of so many residents, as well as grief over losses.

How to help your staff during the pandemic

You know each and every one of your staff members like the back of your hand. You are familiar with their personalities, their quirks and what makes them tick. You are trained in the very nature of this valuable work, and how to help prevent burnout. However, this pandemic is like nothing you — or anyone else — has encountered before. The finest thing you can do is to talk, listen and support. Show your staff that you and everyone else are in this together.

If you can afford it, offer individual staff members a day, or even a few hours respite. If time allows, organize small group sessions, and let everyone just vent. Some people are very vocal. Others are private and may be holding back. If they know you are supporting them, this can make the difference between a total breakdown and the strength to continue for just one more hour, day or week.

Other causes of burnout

Unfortunately, burnout in nursing homes was an issue prior to COVID-19. People need to be cared for, and sometimes the people responsible can only handle so much. As the owner of a nursing home, you're going to want to keep patients in tip-top condition for the entirety of their lives. You'll obviously want to provide the best service, but their lives and overall health matter more.

So, if you're wondering what might make staff at a nursing home burnout, here are a few of the leading causes. Hopefully, you can take these on board when you next evaluate your staff:

Stress

Most jobs in the world come with a fair amount of stress. The top jobs that pay the most are often the most stressful, so it's not exclusive to nursing home employees. That doesn't mean the job can't raise one's blood pressure exponentially. You never know what could be going on in a nurse's home — they could walk into work

already on edge, and find themselves in a pretty awkward position in their professional lives, too. If you see your employee looking a little stressed out, you might want to sit with them and have a little chat about things.

Lack of support

If a care worker or nurse has lots to do, then they're going to need a lot of help. Now, this could mean they need a little pat on the back from their superior — everyone likes an arm around the shoulder — or it could mean bringing in extra bodies into the nursing home to lighten the load. When someone is left isolated during tough times, it only adds to the issues that they may already be facing.

Lack of job fulfillment

Nursing homes can be inspirational places to work. Doing things for others and boosting their quality of life is a very fulfilling thing to do. Sometimes, however, that kind of thing runs out. It's completely natural and normal to become used to something — a person becomes desensitized by anything if they're exposed to it too much. If they feel as though their job and their lives are going nowhere, then it can be a big strain on their working day.

Poor mental health

If a staff member is vulnerable to depression, then a hard-hitting job such as working in a nursing home can be quite the struggle. Not everyone openly displays signs of mental health struggles, but if they do, then it's best to sit down with them and talk things through. In fact, you'll probably need to have a little chat with all members of your team — you truly never can be too sure.

Fund All Costs for COVID-19 Testing of Senior Living Staff, LeadingAge CEO Asks Leaders in Congress

Congress holds the key to the funding of tests for senior living staff, which is not being taken care of properly. The CEO of LeadingAge wants to see that change across the country in order for the industry to be stronger and more prepared in the future.

6/1/2020

Written by: Lois A. Bowers

Congress should fund the cost of COVID-19 testing for all staff members, including repeat testing, in assisted living communities, continuing care retirement communities (also known as life plan communities) and affordable seniors housing communities and other congregate settings where it is required, such as nursing homes,

LeadingAge President and CEO Katie Smith Sloan said in a letter to Republican and Democrat leaders in the Senate and House.

“[T]he costs — all the costs — test kits, PPE and staffing — must be borne by government,” she said in a May 28 missive.

The request was one of several made in the letter, in which Sloan said Congress should “focus additional attention and resources on COVID-19 testing in all settings that serve and care for older people” — including senior living communities and affordable seniors housing — not just nursing homes.

“COVID-19 disproportionately affects older persons, persons living in close quarters or congregate living, and the people who serve these elders,” she wrote. “We hope you will further address the continuing challenges our members face in responding to this crisis and its extraordinary impact on them and the people they serve.”

Assistance is needed at the national level, Sloan said, adding that it is “irresponsible” for the U.S. government to tell nursing home providers to “talk to your governor” to secure supplies and funding for testing, and “it would be equally inappropriate to ask other aging services providers to do the same.”

Congress, she said, should ensure that federal policies and financing support testing whenever COVID-19 is suspected and support testing of all residents in congregate settings whenever anyone in the setting tests positive. In non-nursing home settings, mobile teams or other on-site alternatives should be funded to conduct testing, Sloan said.

To ensure that enough tests are produced to meet demand, quickly, Congress should mandate that the administration use the Defense Production Act, the letter said.

Any aging services provider that conducts COVID-19 testing should have guaranteed access to Centers for Disease Control and Prevention-recommended personal protective equipment needed to do the testing, Sloan added. Also, she said, a fund should be established to pay for temporary staffing when employees test positive for the disease and must be quarantined for 14 days.

Testing also should be available and affordable so that family members can visit residents in congregate settings, Sloan said.

And Congress also must address the unique testing needs in affordable seniors housing, she said.

“Affordable senior housing providers do not have the desire or capacity to administer tests but do want residents and staff to have access to testing,” Sloan said. “In these communities, local health departments must work with affordable senior housing communities if a resident tests positive; residents are not required to disclose such information and affordable senior housing communities cannot ask residents about their health status. And, affordable senior housing providers need federal funding support to ensure they can practice effective infection control.”

New article on next page…

Balancing Safety, Quality of Life in the COVID-19 Era

Landmark Senior Living has learned several about the resiliency of their operating staff over the past few months. A new balance of safety and quality of life has been implemented on the grounds of every Landmark Senior Living community as the state of well-being continues to change.

Written by: Lois A. Bowers

6/1/2020

Pavlo Kononenko doesn't think his company's approach to battling the effects of COVID-19 is unique, but what he described in a recent blog certainly is different from media reports that portray senior living residents as lonely and isolated from fellow residents, and family members as pleading to see them after months of separation.

Yes, things are different than they used to be at Landmark Senior Living's five assisted living and memory care communities — four in Massachusetts and one in New Mexico. Staff members are wearing personal protective equipment and carrying out rigorous infection control regimens, for instance.

Except for a few days in March when "everybody stopped everything," however, the company has maintained socially distanced dining in community dining rooms, with residents traveling the hallways to and from meals and interacting with one another, Kononenko, Landmark's president, told me. Group activities have continued as well, albeit with limits on the number of residents who can participate on any given day due to social distancing.

And although the company facilitated video chats between residents and family members, they "simply did not compare to personal visits," he said. Since about mid to late April, weather permitting, residents can visit with their loved ones while socially distancing outside in special areas. ("We had residents tear up the first time they saw their families again," Kononenko said.).

"We were concerned that if we confined everybody to their rooms, they would be safe from COVID, but that won't save them from dying because they will decline, mentally and physically," Kononenko said. "So we had to strike this very delicate balance of making sure that we keep residents safe from COVID but also preserve as many quality-of-life activities as possible."

Landmark had been proactive in stopping nonessential visits and tours before any guidance was issued advising those practices, he said. Actions affected staffing, too.

"In one of the communities, we did have an aide who worked at our facility as well as at one of the nursing homes that had a pretty bad outbreak," Kononenko said. "So they had to tell the staff right away, 'Pick a place where you work, but you can't work at multiple places anymore.' "

Members of the company, which has a history of more than 20 years of operational experience, kept abreast of the latest science and news reports as well as local, state and national orders and guidance, he said.

“We understood pretty early on that this is not something that will be done in a week or two, like a flu outbreak,” Kononenko said. “If it were something like that, then you could lock down, weather the storm for two weeks and then everybody’s happy. We saw that this will go on for months.”

So Landmark worked closely with local and state health departments and regulators to try to develop an approach to COVID-19 that maintained resident quality of life as much as possible, he said.

“We wrote to them and said, ‘Are you really comfortable with these guidelines? People will start dying if they’re confined to 300 square feet of space and they’re living their last year or two of their lives and they aren’t allowed to see family or anything like that,’ ” he said. Landmark soon received approval for its approach as long as people practiced social distancing and proper hand hygiene and took other precautions.

The company, Kononenko said, continues to monitor the situation to ensure that residents remain safe. That includes tightening restrictions as necessary if COVID-19 appears — and it has appeared in three of the Massachusetts communities. (One community has had between two and 10 cases, according to state officials, who report ranges, not exact numbers, for staff and residents. Another community has had 10 to 30 cases, and a third has had more than 30 cases.) Staff cases in one community, he said, were isolated quickly, and spread to residents was prevented due to actions such as mask-wearing.

Kononenko said he expects the use of PPE and disinfectants to be the new normal for many months to come but said Landmark will continue to try to balance safety and quality of life for residents.

As he wrote in his blog, “The best we can do is take it one day at a time, continuing to weigh risks, maintaining strict adherence to safety protocols and patiently wait for the arrival of the vaccine.”

And although he doesn’t think Landmark is unique in its actions, “I think what’s essentially different about us is that we realized that COVID is something that will take place for a very long time, so we started putting these procedures in place pretty early on,” Kononenko said. “So while you might hear that some other places are ‘loosening up’ and maybe going too far with that, we established pretty strict rules about how to give people quality of life pretty early on.”

Skilled Nursing News

Inside Vivage’s COVID-19 Testing Triage: By Targeting Nursing Home Workers, New Cases Go ‘Down to Zero’

Early testing for COVID-19 is key to population health, most significantly when dealing with those in close contact with the senior population. Some facilities have taken serious steps to detect any infection of their staff which allows the spread to stop sooner.

Written by: Maggie Flynn

6/1/2020

One of the primary factors in the spread of COVID-19 in skilled nursing facilities is the workforce — specifically staff members in a facility who are infected with the virus while not showing any symptoms of illness.

Regardless of whether or not those infected do begin to show symptoms, they can still pass on the virus, rendering symptom screenings — such as testing for fever and checking for cough or shortness of breath — ineffective in keeping it from getting inside a SNF. That makes widespread testing of staffers and residents paramount.

But in a time of scarce testing resources, operators have had to make hard decisions about who receives a test for COVID-19, or scramble to arrange their own partnerships to make sure they had the capacity to test in the event of an outbreak.

And while guidance on reopening nursing homes from the Centers for Medicare & Medicaid Services (CMS) issued on May 18 recommends that SNFs have the capacity to test staff once a week, among other benchmarks, the language of the guidelines emphasizes flexibility for states and does not appear to be a mandate, despite how forceful the recommendations are.

Vice President Mike Pence and President Donald Trump recommended ramping up testing in nursing homes at the federal level, but states have been left largely in charge of securing testing for COVID-19, and their strategies for testing among nursing homes varies widely.

West Virginia, for instance, was quick to call for testing at nursing homes, and over the past few weeks, other states have issued either mandates or goals to test all residents and workers in long-term care at least once. In Colorado and Utah, testing has gradually come to focus on the staffers at long-term care and congregate living settings, but with different nuances.

Colorado's testing initiative in nursing homes will focus on staffers over the next eight weeks, according to a May 22 Colorado Public Radio News report, based on work done at Colorado State University (CSU) that zeroed on the testing of nursing home workers due to the risk they pose for bringing in infection. The testing performed by CSU showed significant numbers of presymptomatic or asymptomatic workers – and allowed the SNFs where they worked to send them home to isolate and recover.

Utah also is focusing its testing efforts on workers in long-term care and congregate settings, according to a May 11 report in the Salt Lake Tribune.

The efforts of both states highlight how the call to "test, test, test," which has become a mantra of sorts since the pandemic began gathering steam in the U.S., can be implemented — and how the reality of supplies and risk and time affect those strategies.

'I've got nursing homes if you've got tests. How do we make this work?'

As COVID-19 began to spread across the country, the shortage of testing was a major concern for Dr. Nicole Ehrhart, director of the Columbine Health Systems Center for Healthy Aging at Colorado State University (CSU).

It was a point she and her colleague, CSU virologist Greg Ebel, discussed on a conference call held with multiple health care stakeholders in Colorado in the middle of March.

The concern both she and Ebel raised was that in addition to scarcity of tests, the testing was limited to people with symptoms; both Ehrhart and Ebel believed that there was some level of pre-symptomatic infection by those infected, or that in some cases, those infected might never develop symptoms at all.

Ebel's work involves surveillance as a means of understanding disease, and given the concerns about COVID-19's risk to people of older age in congregate settings such as SNFs, both wanted to focus their efforts on this population.

"I said: I think we should think about doing surveillance in these SNFs," Ehrhart told Skilled Nursing News in a May 18 interview. "But the actual people we're most interested in are the workers, because at that time, they had shut down visitors … and then they were screening workers for just symptoms, so fever, cough, history of coughing, etc., or history of exposure."

That mid-March conference call had so many participants on it that Ehrhart's pitch to focus on workers almost got lost in the number of voices.

But Dr. Gregory Gahm, the general medical director at Vivage Senior Living, which operates almost 30 facilities in Colorado, was able to hear her argument for screening workers. He just didn't know who was making it at the time. But with some help from an employee of the state, he was able to connect with Dr. Ehrhart.

"I got in touch with Nicole and I said: Hey, I've got nursing homes, if you've got tests. How do we make this work?" Gahm told SNN.

For Gahm, testing residents for COVID-19 has never struck him as the best use of the resources available, since tests are hard to get and — in the first few months of the pandemic — results were slow to come back.

While the impulse to test every resident is a typical part of the medical mentality of testing — diagnosing and treating — the fact remains that testing is hard to obtain and there is no treatment for COVID-19, he told SNN. Vivage had already stopped communal dining for residents, and was testing resident temperature and oxygen three times a day; if symptoms emerged, they would be addressed, but that didn't require a positive or negative test.

Asymptomatic workers were another matter entirely.

"What we really are learning is that you've got to get the asymptomatic carriers out of the facility," Ebel told SNN on May 19. "And the only way you can do that is by testing them and asking them to self-quarantine for 14 days."

To launch the testing partnership, Vivage chose a couple of SNFs to start, roughly in mid-March, and Gahm trained the staffers on how to perform the test correctly. The results were such that two more facilities were added to the pilot, and then a fifth and a sixth.

The tests led to some surprising findings. One facility with 120 patients and 100 staff saw no positive staff members, while in one facility with 75 patients and 70 staff who chose to participate, 14 nurses tested positive in the first week, while "14 or 15 other staff members" were positive, Gahm told SNN.

"That was devastating to them; it took out more than half of their nursing staff and a whole bunch of other people, and they really had to scramble to make things work and keep people there," he said.
But two weeks later, those workers could return. And one other key part of catching the workers early is that the impact on cases was tangible.

"What we've learned is that, as we told people to go home if they're positive, the number of new cases has gone down, down, down — down to zero in most of the facilities," Ehrhart told SNN. "There's still some facilities that have a very low, kind of smoldering amount of it still in this worker population. But we're seeing that number of new cases in workers decrease."

That suggests that early identification of COVID-19-positives before they show symptoms can reduce the number of new positive cases, she said.

The state of Utah has also zeroed on workers as a testing priority, because nursing homes and other long-term care facilities have been in lockdown since the middle of March, Utah Department of Health public information officer Charla Haley told SNN on May 19.

"The way [facilities] get a case is through exposure to an asymptomatic staff person who got it somewhere in the community," she said. "So we are starting with just doing baseline testing in staff. We are starting with facilities at highest risk for larger outbreaks, i.e., those with memory care units, those with behavioral or intellectually disabled patients, and those with ventilated patients."

Once that baseline test is complete, the state wants to implement infection control improvements on these specific units, including the limiting of staff movement and repeated testing of staff on the unit on a weekly basis, as well as improving use of and access to personal protective equipment (PPE), she said.

Research to reality in Colorado

After the success of the five-facility pilot in Colorado, the project was expanded, and now Colorado is planning to test all nursing home staff in Colorado every day for eight weeks.

However, there are some crucial factors that might make it hard to replicate elsewhere. The CSU lab had been studying the West Nile virus and was able to repurpose to study COVID-19 and add "enormous capacity," Gahm said, but this entailed changing equipment and pivoting to make use of emergency authorizations on the state and federal level.

While the reverse transcription polymerase chain reaction (RT-PCR) testing done for COVID-19 is done "all the time in research labs," these labs are not clinical labs, and the work is being done as a research effort — even though it's the same testing as those done at CIIA-certified (Clinical Laboratory Improvement Amendments) labs, Ehrhart explained.

As a result, any positives that CSU finds need to be verified by a CLIA-certified diagnostic lab. And because the data is anonymized, CSU only has a case number for each positive.

When it comes to transmitting the results to workers in a timely manner, however, this isn't as major an issue as it might sound. At the same time that CSU sends the COVID-19 positives to the CLIA lab, it sends the results to Gahm as well; Gahm can take the case number and find the associated name to contact the administrator, who

can then notify the positive worker. Even though it might take a few days to get the person's data to the state health department, the positive person knows "usually within hours of the time the test is run," Gahm said.

But there were other hurdles that other testing initiatives in the country should keep in mind. At the beginning of the pilot, Ebel and Ehrhart were self-funding the project with startup funds Ehrhart had on hand because of her August 2019 assumption of the directorship at CSU's Center for Healthy Aging. The state, at that point in March, was not ready to finance the study, given the chaos of the times and the fact that things were starting to escalate, Ehrhart said.

"We just said: This is so important, this is going to save lives," she told SNN. "If we delay even by a week, it's a matter of cost of lives. So we'll just self-fund this."

The other challenge is that CSU has some unique qualities that make it able to do this type of work. The university has a large number of labs that are Biosafety Level 3, the level needed for this research on various infectious diseases. But not every local research lab has that level of clearance.

Then there's the personnel needed who can do the research on de-identified samples and work with local health officials on reporting and compliance.

"So it's not quite as simple as reaching out to a research lab," she said.

CMS administrator Seema Verma has said that states have either untapped or sufficient testing capacity, but Gahm believes the picture is more nuanced than that: He believes this is excess "potential" lab capacity, citing the pivot by CSU from West Nile to COVID-19. If labs cross the country repurposed for COVID, that would lead to plenty of capacity, he said. But it's hard for them to do so overnight.

"You could do that at lots of universities and other labs," he said. "You could do that, but I don't know that people have done it."

It's also important to remember that the CSU initiative is a not a public health directive but a research project, albeit a crucial one. The surveillance testing over eight weeks will provide valuable information on the virus and how it behaves, particularly in terms of how it shifts as communities open up, Ehrhart said. That will have ramifications for visitation rules and how to adjust to changes outside the SNF walls, she said.

But because it's a research project, there's no requirement that employees participate, and as Ehrhart observed, "it isn't exactly convenient for everybody to have their nose invaded weekly."

Staff at Vivage felt the same way, Gahm said.

"We found anywhere to 20% to 50% of staff don't really cherish the idea of having a swab poked back into your nose so it comes down to your throat and then you do it on the other side — every week for eight, 10, 12 weeks," he told SNN.

And there's one other crucial factor: the supplies of the tests themselves. As more and more states set mandates for nursing home resident and staff tests, that will mean exponentially increasing the tests provided.

There are roughly 210 nursing homes in the state of Colorado, with the average nursing home having 120 staff members, plus roughly 10 extra other essential workers, Gahm explained. That means each week, 210 nursing homes would need 130 test each. And that doesn't include assisted living facilities.

"From what I can tell, they don't have enough tests," Gahm said when asked about the expanded push to test in Colorado. "They're kidding themselves. We can do a lot more facilities, but I just can't see that there are enough tests unless somebody is willing to step up and say … we're only going to test hospitals and nursing homes and critical personnel. If they were willing to do that, there might be enough tests to do that."