Canadian Journal on Aging / La Revue canadienne du vieillissement

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COVID-19 and the Experiences and Needs of Staff and Management Working at the Front Lines of Long-Term Care in Central Canada

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Article

Cite this article: Reynolds K, Ceccarelli L, Pankratz L, Snider T, Tindall C, Omolola D, Feniuk C, & Turenne-Maynard J. (2022). COVID-19 and the Experiences and Needs of Staff and Management Working at the Front Lines of Long-Term Care in Central Canada. *Canadian Journal on Aging / La Revue canadienne du vieillissement* **41**(4), 614–619. https://doi.org/10.1017/S0714980821000696

Received: 02 October 2020
Accepted: 25 October 2021

Mots-clés:
vieillissement; COVID-19; soins de longue durée; stress; fardeau des soignants; quantitatif; qualitatif

Keywords:
aging; COVID-19; long-term care; stress; caregiver burden; quantitative; qualitative

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Résumé

Aux quatre coins du globe, les soins de longue durée ont subi une pression supplémentaire tout au long de la pandémie de COVID-19. La présente étude est la première à examiner les expériences et les besoins du personnel et de la direction de centres de soins de longue durée pendant la pandémie de COVID-19 au Canada. Un sondage en ligne a été mené auprès d'un groupe de 70 participants comprenant des employés et des gestionnaires œuvrant dans des institutions publiques de soins de longue durée dans le centre du Canada. Des mesures quantitatives validées ont été utilisées pour évaluer le stress des soignants et leur fardeau perçus, tandis que des questions ouvertes ont permis d'explorer les facteurs de stress, les moyens pour gérer ce stress, et les obstacles entravant l'accès aux services de santé mentale. Les résultats indiquent des niveaux modérés de stress et de fardeau pour les soignants, et mettent en évidence des facteurs de stress majeurs associés au travail en soins de longue durée pendant la pandémie de COVID-19 (c.-à-d. changements rapides des lignes directrices relatives à la pandémie, augmentation de la charge de travail, « répondre aux besoins des résidents et des familles », peur de contracter la COVID-19, peur que la COVID-19 arrive dans les établissements de soins de longue durée, et inquiétude quant à l'opinion publique négative envers le personnel des établissements de soins de longue durée et envers ces établissements). Un petit sous-groupe (13,2 %) de notre échantillon a mentionné avoir eu recours à des services en santé mentale pour faire face au stress lié au travail, et la plupart des participants ont affirmé avoir rencontré des obstacles dans leur recherche d'aide. Les nouvelles observations issues de cette recherche soulignent les besoins importants et non satisfaits de ce segment de la population à haut risque.

Abstract

Across the globe, long-term care has been under increased pressure throughout the COVID-19 pandemic. This is the first study to examine the experiences and needs of long-term care staff and management during COVID-19, in the Canadian context. Our group conducted online survey research with 70 staff and management working at public long-term care facilities in central Canada, using validated quantitative measures to examine perceived stress and caregiver burden; and open-ended items to explore stressors, ways of coping, and barriers to accessing mental health supports. Findings indicate moderate levels of stress and caregiver burden, and highlight the significant stressors associated with working in long-term care during the COVID-19 pandemic (i.e., rapid changes in pandemic guidelines, increased workload, "meeting the needs of residents and families", fear of contracting COVID-19 and COVID-19 coming into long-term care facilities, and concern over a negative public view of long-term care staff and facilities). A small subset (13.2%) of our sample identified accessing mental health supports to cope with work-related stress, with most participants identifying barriers to seeking help. Novel findings of this research highlight the significant and unmet needs of this high-risk segment of the population.

Long-term care facilities have experienced one of the biggest impacts associated with the COVID-19 pandemic, with more than 81 per cent of Canada's COVID-19 deaths occurring in long-term care (Government of Canada, COVID-19, n.d.; Holroyd-Leduc & Laupacis, 2020). Media headings such as "Canada's long-term care system failed elders before and during COVID-19" (CTV News, 2020) and "Manitoba care homes say they're chronically underfunded, understaffed, need government funding" (CBC News, 2020) have drawn attention to the under-funded, under-resourced, inadequately maintained, ill-prepared, and deeply upsetting

conditions in vital care facilities that house a large and increasing number of Canada's aging population.

Physical distancing, including keeping a 2 m distance between individuals, in addition to public health restrictions surrounding social gatherings (i.e., visitation in residential homes, hospitals, and long-term care settings) are important infection control strategies that have been employed to reduce COVID-19 infection transmission. Although significantly impactful in slowing the spread of the virus within Canada, the practice of physical distancing has and will continue to have negative side-effects, particularly for vulnerable populations, including older adults residing in long-term care, who may require a higher degree of support surrounding their practice of and regulations for distancing. For example, older adults residing in long-term care may require more frequent reminders concerning distancing practices and may experiences challenges with these sudden changes that include reduced touch from family and staff members. Further, care practices in long-term care such as feeding, bathing, toileting, and dressing, require close contact. The unintended effects of physical distancing can include loneliness, social isolation, stress, anxiety, and depression (Le Couteur, Anderson, & Newman, 2020). Within central Canada, in March 2020, Manitoba government put forth regulations to postpone in-person visits from family and friends in long-term care facilities to minimize risk of infection to residents. Starting in May 2020, with the reopening of provincial business, services, and public facilities, long-term care facilities began permitting pre-scheduled, individual, regulated outdoor physical distance visits. Procedures are quickly changing within and across long-term care facilities, and decisions are being made to adapt visitation depending on level of concern related to COVID-19 and virus outbreak status within specific long-term care facilities. This rapidly changing environment is likely to result in increased stress by long-term care staff, as they navigate ongoing changes in protocol, communicate with residents and family regarding changes and procedures, and try to balance the importance of safety from the virus while also seeking to provide opportunity for contact between residents and their loved ones.

Prior to COVID-19, research described the challenges of working in long-term care facilities, and risks of stress and burn-out (Boerner, Gleason, & Jopp, 2017). These risks have been shown to be heightened during the COVID-19 pandemic (Van Houtven, DePasquale, & Coe, 2020; Yardley & Rolph, 2020), which is attributed to staff working long shifts with little opportunity for breaks or sleep before starting another shift, lack of time for them to process events that occurred during their work shift, reduced availability to provide desired care because of decreased resources, lack of clear guidance or training on COVID-19 protocols, and lack of available protection from the virus, putting their health in danger and leading to increased risk of disease exposure (Williamson, Murphy, & Greenberg, 2020). Physical distancing requirements may limit the emotional and physical support or coping strategies that long-term care workers may have practiced prior to the pandemic, thereby contributing to increased stress and burn-out. Further, observing deaths among their long-term care residents and witnessing the pain of family members who were not able to spend time with their loved ones prior to their deaths as a result of visitor restrictions may also worsen levels of stress and burn-out (Van Houtven et al., 2020; Yardley & Rolph, 2020). This is a field that is in need of much progress at this time in our history, in terms of understanding the experiences of front-line staff and management working in long-term care during the COVID-19 pandemic, and understanding their service-related needs. There is a lack of Canadian research that has described the experiences and needs of staff and management working at the front lines of the COVID-19 pandemic within long-term health care.

Objectives

The objectives of this study were to examine: levels of perceived stress and caregiver burden, first-person accounts of "biggest stressors" associated with working in long-term care during the COVID-19 pandemic, first-person accounts of "ways of coping" with these stressors, and barriers to accessing mental health supports and services in a central Canadian sample of long-term care staff and management.

Method

Participants and Recruitment

Ethics board approval was obtained from the University of Manitoba Research Ethics Board in addition to the individual research ethics boards of long-term care facilities across Manitoba. The Manitoba Association for Residential and Community Care Homes for the Elderly assisted in providing a list of long-term care facilities to contact concerning study participation, as well as by posting our study advertisement in their online newsletter. Executive directors of long-term care facilities in Manitoba received a link to an online consent form and survey through the Qualtrics platform, which they distributed to staff and management working in their facilities.

Procedures and Measures

Participants completed an online survey, available in English only, which took an average of 20 minutes to complete. Data was collected between July 8 and August 10, 2020, and 102 responses were collected. However, upon review, data from 32 participants indicated that they had not continued past the first page of questions (completing some of the work-related characteristics and leaving all other responses blank); Therefore, the final data set included data from 70 participants. Following provision of consent, participants responded to items regarding their work-related characteristics (i.e., position in long-term care, years worked in long-term care, hours worked per week in long-term care), quantitative measures of perceived stress (Perceived Stress Scale; Cohen, Kamarck, & Mermelstein, 1983) and caregiver burden (Zarit Burden Interview-Short Form; Bedard et al., 2001), and open-ended items inquiring about stressors ("What are your biggest stressors related to your current work in long-term care during the COVID-19 pandemic?"), ways of coping ("How have you been coping with the stressors that you identified in the previous question?"), and barriers to accessing mental health supports and services ("What barriers did you face in accessing service [if any]?").

The Perceived Stress Scale (PSS) is a 10-item scale used widely across research studies to understand how situations impact our emotions and stress levels. Participants respond to 10 items on a five-point Likert scale with response options ranging from 0 = never, 1 = almost never, 2 = sometimes, 3 = fairly often, and 4 = very often. After reverse-scoring items 4, 5, 7, and 8, total score is calculated by summing the 10 individual items. Scores ranging from 0 to 13 indicate low perceived stress, scores ranging from 14 to 26 indicate moderate perceived stress, and scores ranging from 27 to 40 indicate high perceived stress (Cohen et al., 1983).

https://doi.org/10.1017/S0714980821000696 Published online by Cambridge University Press

Strong psychometric properties are evident for the PSS (Cohen & Williamson, 1988).

The Short Form Zarit Burden Interview (ZBI-12) was designed to measure distress associated with caregiving. We changed the wording of "relative" in the ZBI-12 to "residents/patients" in our survey, to reflect caregiving within the context of long-term care. Participants respond to 12 items on a five-point Likert scale with response options ranging from 0 to 4, with 0 = never, 1 = rarely, 2 = sometimes, 3 = quite frequently, and 4 = nearly always. ZBI-12 has been widely validated as a screening tool in health populations. Total scores are calculated by summing 12 items, with scores of 0–10 indicating no to mild burden, 10–20 indicating mild to moderate burden, and greater than 20 indicating high burden. Strong psychometric properties are evident for the ZBI-12 (Lin, Wang, Pai, & Ku, 2017).

Analytic Strategy

Descriptive statistics were used to quantify work-related characteristics, perceived stress, and caregiver burden. Open-ended text responses were analyzed following thematic analysis (Braun & Clarke, 2006, 2019), with the use of NVivo qualitative research software to assist with data organization (QSR International, 1999). Thematic analysis followed these stages: familiarization with data, line-by-line coding, development of larger meaning units for line-by-line codes, development of initial thematic framework naming and defining themes and sub-themes, and review of thematic framework. Rigor – the quality, transparency, and thoroughness – of qualitative analysis was assured by documenting a detailed audit trail of the coding process and thematic framework development. NVivo hierarchy charts and maps were used to assess the representativeness of themes and sub-themes in the data. Authors reviewed the thematic framework, discussed views/discrepancies, and arrived at consensus concerning the resulting themes and sub-themes. Participant quotes have been labeled with participant number as well as whether that participant worked in administrative or clinical positions.

Findings

Sample Characteristics

Seventy long-term care staff and management working in Manitoba, Canada completed our survey. Types of professions identified by participants included manager (28), registered nurse or clinical resource nurse (10), administration/human resources staff (5), staff education/development practitioner (5), nutrition and food services staff (4), spiritual care practitioner (4), recreation facilitator (3), health care aide (3), housekeeping staff (2), rehabilitation assistance staff (2), social worker (2), and geriatric mental health clinician (2). All participants provided direct care to residents throughout their work shift, largely because of the COVID-19 pandemic and increased demand for resident care. However, time spent providing direct resident care was not measured in the current study. Participants reported long-term care work experience ranging from 10 months to 42 years, with an average of 12.1 years of experience (standard deviation [SD] = 9.9). Participants held both part-time and full-time positions and reported working an average of 39.6 hours per week, ranging from 20 to 89 weekly hours (SD = 11.7). A total of 12 participants worked 45 hours per week or more. Average levels of caregiver burden fell within the moderate range (mean [m] = 16.0; SD = 7.6), with individual scores falling between low (3) and high (33) perceived burden. Average levels of perceived stress also fell within the moderate range (m = 21.9; SD = 5.7), with individual scores falling between low stress (6) and high stress (36). When examining caregiver burden categorically, 33.8 per cent fell into the moderate range in terms of perceived level of caregiving-related burden, and 20.6 per cent fell into the high range of caregiver burden. When examining perceived stress categorically, 60.3 per cent of the sample reported moderate stress and 14.7 per cent reported high stress. Results of an independent samples t test demonstrated that participants who reported performing administrative roles do not differ from those performing clinical roles with regard to self-reported hours worked per week ($t[58] = -0.599$, $p = 0.551$), perceived stress ($t[48] = -0.293$, $p = 0.771$) and caregiver burden ($t[43] = 0.124$, $p = 0.902$).

Biggest Stressors

Participants responded to an open-ended text-based question asking about their biggest stressors related to current work in long-term care during the COVID-19 pandemic. The central theme across participant responses was the challenge in adjusting to the complex, dynamic, and ever-changing nature of stressors experienced during the COVID-19 pandemic. Related to this central, overarching theme of complex and dynamic stressors, five main themes emerged from participant responses, including: (1) changes in pandemic guidelines, (2) increased workload, (3) "Meeting the needs of residents and families", (4) fear of contracting COVID-19 and COVID-19 coming in to their care facility, and (5) concern over a negative public view of long-term care staff and facilities. Many participants described experiencing these stressors simultaneously. For example, one participant described

> Ethical decision making and at times wondering how I will reflect back on it all. There is so much negativity and staff burn-out. The constant change in decision making. Feeling as though you are letting family down. Being unable to follow through with what you used to. Watching residents die while knowing they spent their weeks/months away from family, only to see them in their final hours. Watching spouses of 70 years touch hands through the window and cry." (P13, Clinical)

Changes in pandemic guidelines

Participants described the rapidly evolving pandemic guidelines, and their experience of stress in "keeping up with these changes," (P24, Clinical) "implementing guidelines and protocols," (P12, Administration) and "communicating with other staff, residents, and families about these changes." (P41, Clinical) One participant noted, "Staff are stressed from the many changes that have come in quick succession. Keeping up with the changes in procedures around PPE, etc." (P26, Clinical) Another participant described "the constant changes once something has been put into place." (P3, Administration) Another participant reported

> The rapidly changing guidelines (seemingly daily) give a lot of uncertainty about how I can and should do my job. The mental and emotional energy that it takes adds a lot of stress and frustration as well as depletes the reserves one has. The weariness and fatigue create immense stress. (P64, Administration)

Increased workload

The increased workload during the COVID-19 pandemic has complicated the ability of staff and management to work in a

https://doi.org/10.1017/S0714980821000696 Published online by Cambridge University Press

demanding and ever-changing environment. This increased workload was previously discussed, with regard to the range of hours that part-time and full-time staff and management reported working. One participant noted, "Instead of doing [work in area of job title], I have to facilitate visits and deal with frustrated families. We are all over worked." (P14, Clinical) Another participant reported that because of the increased workload, there is a "lack of extra help to feed the residents or interact with the residents." (P38, Clinical) Another described, "Many extra duties with no additional staffing." (P4, Administration) Issues surrounding funding of long-term care facilities were stressed by respondents. For example: "Not enough funding for operations," (P19, Administration) and "Not enough staff to cover the shift, not enough personal protective equipment per staff member per shift." (P61, Clinical)

"Meeting the needs of residents and families"

In their responses, participants wrote about the degree of care, professionalism, and responsibility with which they complete their work, and in meeting the needs of their residents and families of residents. Meeting the needs of residents and families, particularly their needs for in-person, close, physical contact has not been possible since the emergence of COVID-19. Participants wrote about challenges with: "Managing family visitations and complaints," (P8, Administration) "Ethical conflict and moral distress of not allowing families to see their residents," (P1, Clinical) "Dealing with family's stress and trying to keep morale up for front line staff," (P4, Administration) "Feeling as though you are letting family down. Being unable to follow through with what you used to," (P13, Clinical) and "Watching residents having very limited visitation rights to immediate family which is the cause of much loneliness and mental health worries." (P27, Clinical) Finally, one participant acknowledged the loss of family visitors as an integral part of the stress experienced by the health care team in long-term care, "Not being able to allow families to participate in their loved ones' care plans. Family members are a part of the health care team and not having their visits, involvement, and of course support for their loved ones was very stressful." (P37, Administration)

Fear of contracting COVID-19 and COVID-19 coming "into the facility"

Participants described worries concerning the transmission of COVID-19: "Fear that someone will bring COVID-19 into the facility. And then staff will not come to work;" (P34, Clinical) "Worrying about bringing COVID-19 home to my family and vice versa." (P38, Clinical) Participants also reported concern over safety protocols and availability of personal protective equipment (PPE): "Uncertainty of supply for protecting residents and staff," (P17, Administration) "Having enough PPE having enough cleaning chemicals," (P10, Administration) "Biggest stressors have been trying to find adequate PPE supplies." (P36, Administration)

Negative view of long-term care staff and facilities

As a final main theme emergent in this analysis, participants described concern regarding media coverage and public perception of staff working in long-term care facilities as impactful stressors. For example, participants described, "Bad publicity of other personal care homes," (P43, Administration) and "The impact of negative publicity/media coverage." (P11, Administration) Another participant noted, "It would be nice if positive stories about personal care homes were made news-worthy." (P50, Clinical)

Coping with Stressors

In spite of the complex, dynamic, ever-changing, and significant stressors experienced by long-term staff and management during the COVID-19 pandemic, many important and helpful coping strategies were described by participants. We categorized participants' coping strategies into five themes: (1) embracing time away from work, (2) relying on support from colleagues, (3) practicing cognitive coping, (4) and employing pandemic safety measures. Many participants mentioned a fifth theme: feeling stuck in stressful experiences and coping.

Embracing time away from work

Participants described the importance of "taking days off," (P40, Administration) "resting during days off," (P42, Clinical) and making the most of this time. One participant noted, "I use my days off to unwind and stay away from work as much as possible." (P58, Clinical) Participants described involvement in a range of hobbies during time away from work, including gardening, being outdoors, watching television, reading books, cooking, and baking. For example, one participant described the importance of, "Music, television, playing games with my kids." (P55, Clinical) Exercise was another important way for participants to spend time away from work. For example, participants noted: "Trying to exercise as much as possible" (P47, Administration) and "daily yoga." (P28, Clinical) Self-care/self-help was also important to participants, with strategies including mindfulness, meditation, and relaxation breathing. Being with family and friends, whether seeking emotional support or distancing from work-related stress, was also reported by participants as a way to cope with current stress. Several participants also described seeking additional support through counselling, psychology, or medication treatment.

Relying on support from colleagues

The importance of "support from peers and colleagues" (P8, Administration) was noted by many participants. Frequent meetings and updates were mentioned by many participants as a positive way to cope with stress. For example, participants noted: "Daily meetings regarding COVID-19 updates and new government guidelines" (P48, Administration) and "frequent staff meetings and 1:1 conversations." (P11, Administration) Participants also noted the importance of openly expressing feelings and concerns: "Venting to co-workers," (P7, Clinical) "Talking/venting/discussing concerns/issues with co-workers," (P35, Administration) and "Talking with fellow managers experiencing similar stressors," (P48, Administration) as being impactful. Being able to discuss concerns with management was also seen as a valued way of coping with stressors: "Contacting management for answers to my questions." (P26, Clinical) One participant described the importance of discussing balanced information regarding work: "Talk about the positives of personal care homes and discuss the constant changes with co-workers." (P43, Administration) Though many participants mentioned support, some respondents indicated their need for increased work-related support: "[There is] some debriefing but not nearly enough." (P13, Clinical)

Practicing cognitive coping

Participants reported the use of cognitive coping techniques in managing stress related to working in long-term care during the COVID-19 pandemic. These ways of thinking included present moment focus, employing humour, and problem solving. With regard to present moment focus, participants spoke about a

https://doi.org/10.1017/S0714980821000696 Published online by Cambridge University Press

moment-to-moment or day-by day strategy to help them to cope: "Taking each shift as it comes," (P61, Clinical)"Taking things day-by-day," (P10, Administration) "Dealing with changes one day at a time;" (P12, Administration) "Going with the flow as much as I can," (P9, Administration) and "Knowing this won't last forever." (P28, Clinical) With regard to humour, participants discussed looking on the bright side and trying to find "Humour" (P36, Administration) in the day or in the current times. Others described problem solving around stressors: "I think a lot and try to find solutions." (P2, Administration)

Employing pandemic safety measures

Participants described use of pandemic safety strategies to cope with stressors. For example, "By wearing PPE, handwashing, and social distancing," (P44, Clinical) "Proper hygiene, good rest, good food," (P30, Clinical) and "Using PPE even when it is discouraged to do so (i.e., shortages), and lots of hand sanitizer." (P22, Clinical)

Participants also described the importance of staying informed about pandemic-related events and changes through government Web sites to managing pandemic-related stress: "Education: reading recent research articles on COVID-19." (P49, Administration)

Feeling stuck in stressful experiences and coping

Several participants described feeling stuck, alone, and unsure about how to cope with work-related stressors. Increased alcohol consumption was noted by participants: "Started drinking again," (P13, Clinical) and "Drinking when I get home." (P68, Clinical) Other participants reported taking work-related leaves, "Not well, stress leave," (P17, Administration) or considering new employment, "I'm starting to look for another job." (P14, Clinical) One participant explained feeling alone in their coping: "Not well. I have little place at work to process or make decisions with others, so I am on my own and my way of coping is to process out loud." (P64, Administration) Another participant described feeling resigned while experiencing a lack of control over their ability to change work-related situations: "I can't really do anything, I have no control." (P34, Clinical)

Mental Health Support Accessed and Barriers to Access

A small proportion ($n = 9$, 13.2%) of our sample had accessed mental health supports or services to manage stress during the COVID-19 pandemic. This comprised participants working in administration ($n = 2$) and clinical ($n = 7$) position types. The supports accessed included spiritual health resources, counselling, clinical psychology, and psychiatry. When asked about what supports would have been helpful to participants, responses included: counselling, online therapy, online discussion groups, peer support discussion groups, additional staff support, and additional work-related debriefings. When describing barriers faced in accessing mental health supports, participants described time and work-related demands as primary barriers: "Lack of time to focus on anything beyond work," (P8, Administration) and "Time, adjusting workload and now adding extra measures to keep my own family safe." (P18, Clinical) Participants also described barriers concerning reduced availability, elevated cost, and stigma associated with mental health service use. For example, one participant described: "Knowing who to call and the stigma that comes with that. Co-workers finding out and judging." (P61, Clinical)

Discussion

The current study adds to a growing literature base exploring the impact of COVID-19 on long-term care workers and presents the first Canadian data to highlight rates of perceived stress and caregiver burden, as well as personal accounts of significant stressors, ways of coping, and barriers to accessing mental health supports and services. Qualitative findings highlight the central theme of challenges managing complex and dynamic stressors, related to: (1) changes in pandemic guidelines, (2) increased workload, (3) "meeting the needs of residents and families," (4) fear of contracting COVID-19 and COVID-19 coming in to their care facility, and (5) concern over a negative public view of long-term care staff and facilities. Many participants reported their experience of these stressors simultaneously during the COVID-19 pandemic, further impacting upon their mental health and coping. In the face of elevated stress and caregiver burden, many long-term care staff and management reported the use of helpful ways of coping, including: (1) embracing time away from work, (2) relying on support from colleagues, (3) practicing cognitive coping, (4) and employing pandemic safety measures, with some participants mentioning a fifth theme of feeling stuck in stressful experiences and coping. A small proportion of our sample (13.2%) had accessed mental health supports or services, with notable barriers including time and work-related demands, in addition to availability of services, cost of services, and stigma associated with seeking mental health treatment. Canadian findings are in line with findings from other countries, highlighting increased demands placed on long-term care staff during the COVID-19 pandemic, likelihood for worsened stress and burn-out, and an abundance of unmet needs (Clarfield et al., 2020; Van Houtven et al., 2020; Yardley & Rolph, 2020).

Implications

Proposals and editorials have put forward a global call to action, with an immediate need to enhance the safety of long-term facilities – including adequate provision of PPE, improving facility infrastructures, providing continued resident care focused on physical and mental health, and supporting staff in managing increased stress and related mental health problems (Ayalon et al., 2020; Gaur, Dumyati, Nace, & Jump, 2020; Stall, Jones, Brown, Rochon, & Costa, 2020). Findings from our research suggest the importance of communication within long-term care settings regarding continued changes in pandemic-related guidelines. Regular meetings with staff and management were described as a helpful way of coping with work-related stress among participants in our research. The frequency of these meetings, as well as the clarity with regard to messaging regarding guidelines, could enhance the knowledge of guidelines, comfort in practicing according to these guidelines and sharing guidelines with residents' family members, and perceptions of support by colleagues and management. The significant stress of increased workload, with weekly hours up to a range of 89 (in a typical 40-hour work week) in our sample is highly concerning and in need of examination and regulation, with policies developed to protect the health and safety of long-term care staff. This increased workload, more hours worked per week, and provision of additional care roles in comparison with pre-pandemic work schedules (e.g., feeding residents when this was outside of one's initial job description) was likely a product of multiple factors, including working within an under-funded system, staff illnesses and corresponding absences from work, and lack of family visitation. Regarding family visitation, informal familial caregivers

https://doi.org/10.1017/S0714980821000696 Published online by Cambridge University Press

are often seen as an important part of the care team in long-term care settings, providing conversation, recreation, and assisting with other areas of care, including feeding (Zimmerman et al., 2013). The absence of familial care involvement, as well as increased responsibilities to meet family needs, for example by providing more frequent updates and answering evolving pandemic-related questions, was also a likely contributor to increased workload among long-term care staff and management.

Elevated stress and worry among long-term care staff and management, paired with barriers to seeking mental health supports are problematic, and there is a need for mental health professionals to work collaboratively with long-term care organizations in creating services in line with their needs. Emerging evidence suggests that compassion-focused therapy and schema-focused therapy show promising results, although more research is needed in this growing field (Williamson et al., 2020).

Limitations and Conclusion

The authors highlight the small sample size in this research ($n = 70$) as a limitation, and recommend that future research exploring the experiences and needs of long-term care staff and management employ more heterogeneous recruitment strategies to increase sample size. Although it is a strength of this study that our respondents comprised a diverse range of non-clinical staff, only three participants noted that their main position was as a health care aide, which is a limitation given the large number of health care aides working in long-term care. It is important to note that our recruitment methods as well as our study design focused on a reliance on Internet access, which may have prohibited staff who do not have access to a device with the Internet while at work from participating. Our recruitment methods and study design may have been more targeted to individuals with increased availability of time and access to the Internet while at work, potentially leading to sample bias. As such, we may have missed hearing the perspectives of long-term care staff who experience even greater amounts of stress, burden, and challenges while at work. We did not assess time spent providing direct clinical care, nor did we assess sex or gender, which could have been helpful to further contextualize stress and burden among participants. Nonetheless, this study highlights the experiences and unmet needs of long-term care staff and management and adds to current COVID-19-related research across the globe, informing and advocating for a greater standard of care for residents and staff in long-term care during COVID-19.

Acknowledgments. Authors thank long-term care staff and management for their work during the COVID-19 pandemic, and for participating in this research.

Funding. Funding for this work was provided by the Réseau Compassion Network and the University of Manitoba.

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