SGS SOUTHERN GERONTOLOGICAL SOCIETY

Journal of Applied Gerontology
2023, Vol. 42(7) 1582–1587

DOI: 10.1177/07334648231154544
journals.sagepub.com/home/jag
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The Impact of COVID-19 on the Person-Centered Care Practices in Nursing Homes

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Abstract

The COVID-19 pandemic has had a significant impact on long-term care residents, family, and staff. Nursing homes are facing persistent challenges such as staff shortage, lack of personal protective equipment (PPE), and staff experiencing mental health issues including burnout. COVID-19 precautions may have made implementing person-centered care (PCC) in nursing homes more difficult. This report provides a descriptive analysis of perceived COVID-19 impact on the PCC practice in nursing homes. Surveys (N = 379) were collected from 11 nursing homes across Georgia. PCC practice barriers include reduced choice for residents, staff anxiety related to COVID-19 precautions, increased prevalence of short-staffing, and expanded duties for direct care workers. Facilitators for PCC were also present and included staff engagement, the provision of mental health resources, supervisor support, and empowerment of staff. Applied practice and research to address these barriers and expand implementation of facilitators is needed.

Keywords

COVID-19, person-centered care practice, long-term care

What this paper adds

- Elaborates perceived changes in person-centered care in nursing homes
- Identifies barriers to person-centered care exacerbated by COVID-19
- Identifies facilitators for person-centered care impacted by COVID-19

Applications of study findings

- Helps practitioners identify areas to target for quality improvement
- Sets agenda for future research on person-centered care practices
- Informs the development of training and supportive practices for nursing home staff

Introduction

The COVID-19 pandemic has drawn attention to persistent problems that have been plaguing the US long-term care health system for decades (Werner et al., 2020). Nursing homes were poorly equipped to prevent the spread of the virus and their staff was insufficient in number, undervalued, undertrained, and underpaid (Dill et al., 2020; Scales, 2020).

Nursing homes have mandates to complete and implement person-centered care plans because these practices have been associated with improved quality of life and quality of care for residents (Fazio et al., 2018; Koren, 2010; Poey et al., 2017). CMS defines person-centered care (PCC) as "an individualized goal-oriented care plan based on the person's preferences, where care is supported by an inter-professional team in which the person is an integral team member" (CMS Ref: Definitions 483.5). Developed on a medical model, nursing homes often function as mini-hospitals with overhead paging systems, minimal privacy, and inflexible eating, sleeping, bathing, and even toileting routines (Roberts & Pulay, 2018) which inhibits the adoption of PCC practices. Barriers to increasing the primacy of resident preferences for autonomy, dignity, simple pleasures, and meaningful engagement abound in nursing homes (Bangerter et al., 2016;

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Bhattacharyya et al., 2022). Furthermore, the COVID pandemic exacerbated staffing challenges within nursing homes making implementing person-centered care more challenging (Shen et al., 2022).

COVID-19 has exacerbated existing vulnerabilities of workers through increasingly unsafe working conditions, increased workloads, and emotional exhaustion (Shen et al., 2022; White et al., 2021). Media coverage regarding these challenges and heroic efforts of nursing home staff during these difficult times have increased visibility of these long-standing issues (Almendrala, 2020; Lyson, 2022; Scales & Lepore, 2020). In addition to being underpaid and undervalued, nursing home staff experienced additional layers of trauma during the pandemic. These multiple layers of trauma include increased workloads, unclear and often contradictory instruction, emotional overload, stress, fear and exposure to contagion and death, and the dearth of staff and protective equipment (White et al., 2021).

Uncertainty and fear about the unfolding situation resulted in emotional exhaustion, sleep disturbances, and loss of appetite for nursing home staff and residents (Cousins et al., 2021; Kabir et al., 2020; Marshall et al., 2021). Nursing home administrators and owners faced problems in organizing and managing physical and human resources to adequately respond to the pandemic and often failed to address the emotional exhaustion among employees and residents (Cousins et al., 2021; Leskovic et al., 2020; Verbeek et al., 2020; White et al., 2021). Little research to date has described the perceived impact of COVID on PCC practices in nursing homes. This descriptive study gives voice to the nursing home staff who have experienced the impact and elaborates perceived changes (associated with COVID) in PCC in nursing homes. Understanding nursing home staff perceptions of changes to PCC helps practitioners identify areas to target for quality improvement, sets the agenda for future research on PCC, and informs the development of training and supportive practices for nursing home staff.

Method

Sample Recruitment and Data Collection Survey

Data (n = 379) were collected from 11 nursing homes across Georgia in the March-July 2021 as part of a larger study of PCC practices in Georgia nursing homes. The survey measured PCC practices using the Kansas Culture Change Instrument (KCCI) and job quality measures (Sturdevant et al., 2018; Morgan et al., 2013). Drawing from a random sample of 60 nursing homes from Georgia Department of Community Health skilled nursing homes list, we contacted administrators by phone to request permission to conduct the survey. Targeting approximately 25 nursing homes we recruited from this random sample in an effort to maximize geographic diversity and vary on urban/rural status (GA Code § 31-7-94.1 2017), nursing home size, quality ratings, and ownership characteristics. Before the pandemic, the study team recruited 13 nursing homes. When we were able to re-enter the field, we recruited an additional 11 homes (March–July 2021). Working with administrators, we identified a day with maximum staff availability (e.g., pay day or in-service day) and collected data from morning shift change until afternoon shift change in order to access staff across all three shifts. We received 95% of the surveys which we distributed for a $10 cash incentive. Our survey distribution numbers roughly matched administrators' estimates of the number of staff in the building during the data collection but we were not given access to employment rolls to verify. This study focuses on the second wave of data collection.

Survey Instrument and Data Analysis

For the second wave of data collection, we added 21 new questions to assess the perceived impact of COVID-19 on PCC practices. Our larger research team includes four consultants and an advisory board who are nursing home stakeholders, including former administrators, advocates, and surveyors. After consulting with these experts about the challenges facing nursing homes during COVID, we supplemented the existing survey to address new concerns. For example, the original survey asks about resident choice for a variety of daily routines and the supplement asks if "COVID-19 precautions made it difficult for staff to give choice to residents in their daily routines." Other items focused on the impact of COVID-19 and how widespread problems/solutions were. For example, "The Nursing Home is more short-staffed since the outbreak" and "At my job, direct care workers were provided with necessary Personal Protective Equipment." Given the lack of information and psychometrically sound tools on how PCC has been influenced by the pandemic, we chose to develop our own items to systematically assess staff perceptions.

Institutional Review Board approval was obtained from the Georgia State University Institutional Review Board (IRB number H19015). Survey data were cleaned and then analyzed using IBM SPSS 27. Descriptive statistics were used to summarize the results. Each item had response categories of 1–4 (strongly disagree, disagree, agree, and strongly agree). Responses were collapsed into agree and disagree for this descriptive report.

Results

Characteristics of the staff sample are summarized in Table 1. Age ranged from 18 to 88 years; the modal category was 31–50 years of age. The majority of participants in this study were female (88.8%), Black (56%), and half were married (50%). Over half (52.5%) of participants had some college, including an associate degree or certificate. Participants' job titles included Certified Nursing Assistant

Table 1. Descriptive Characteristics of the Sample (*N* = 379).

	N	%	Missing (*n*)
Age			30
18–30	66	18.9	
31–50	142	40.7	
51–70	136	39.0	
71–88	5	1.4	
Sex			22
Female	317	88.8	
Male	40	11.2	
Race			40
Black	190	56.0	
White	144	42.5	
Other	5	1.5	
Marital status			17
Single	132	46.5	
Married	181	50.0	
Divorced	32	8.8	
Widowed	17	4.7	
Education level			137
Bachelor or higher education	34	14.0	
College (associate, certificate)	127	52.5	
High school	70	28.9	
Other	11	4.5	

(*n* = 116, 32%), Licensed Practical Nurse (12.2%), Housekeeping or Laundry Aide (8.3%), and Dietary Aide (8.3%).

Characteristics for the 11 nursing homes are described in Table 2. CMS five-star ratings ranged from 1 to 5 across the sample with a mean of 2.64. Eight nursing homes were located in rural areas. Seven nursing homes were classified as for-profit corporate ownership which is comparable to the proportion nationally. The nursing homes ranged from 60 to 149 beds and all participated in Medicare and Medicaid.

Respondents reported high rates of COVID-19 in their nursing homes. The majority of respondents reported that half or more of their residents and staff in their workplace contracted the COVID-19 virus. Item level results are summarized in Table 3.

Respondents reported that COVID-19 precautions and the realities of the pandemic created challenges and opportunities for PCC practices. The perceived impact of COVID-19 on PCC practices are summarized in Table 4. The majority of staff reported workplace concerns as a result of COVID-19 precautions including anxiety (85%), staff shortages (83%), and that there never seemed to be enough time (62%). Many staff members reported additional barriers which restricted resident-staff relations including their relationships with residents (65%) and

Table 2. Sample Nursing Home Characteristics vs Statewide (*N* = 11).

	Analytic Sample	State Licensed NHs
Star rating (mean/sd)	2.64 (1.43)	2.50 (1.42)
Geographic location (*n*/%)		
Urban vs. Rural	3 (27.3)	53 (14.8)
Ownership status (*n*/%)		
Non-profit	4 (36.4)	106 (29.5)
For-profit	7 (63.6)	236 (65.7)
Bed size (mean/sd)	96.09 (28.29)	110.79 (49.34)
Medicare and Medicaid (*n*/%)	11 (100)	345 (96.1)
Total number of NHs	11	359

*NHs stand for nursing homes*State licensed nursing homes data comes from nursing home compare data download from CMS.gov

Table 3. COVID-19 Impact (in percentage) (*N* = 379).

	0%	1–25%	26–50%	51–75%	76–100%	Missing
Items	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n*
Approximately what percentage of **staff** members in your nursing home were infected with COVID-19?	4 (1.1)	62 (17.4)	88 (24.7)	120 (33.6)	83 (23.2)	22
Approximately what percentage of **residents** members in your nursing home were infected with COVID-19?	8 (2.2)	36 (10.2)	65 (18.4)	104 (29.4)	141 (39.8)	25

Table 4. The Perceived Impact of COVID-19 on Person-centered Care Practices (N = 379).

	Disagree	Agree	Missing
Items	*n* (%)	*n* (%)	*n*
Staff experienced anxiety related to COVID-19 precautions	56 (15.4)	307 (84.6)	16
COVID-19 precautions made it difficult for staff to give choice to residents in their daily routines	89 (25.4)	262 (74.6)	28
Direct care workers were empowered to support residents in creative ways while using COVID-19 precautions	64 (17.6)	299 (82.4)	16
The staff members received recognition for working through the pandemic	134 (37.5)	223 (62.5)	22
Throughout the pandemic, nursing home managers treated direct care workers with respect	68 (19)	291 (81)	20
Residents were able to stay in touch with family members virtually	62 (17.1)	300 (82.9)	17
Residents and staff members were encouraged to talk about their feelings regarding the pandemic	93 (25.8)	267 (74.2)	19
Residents with no symptoms were able to interact with other residents by maintaining the recommended social distance	139 (39.4)	214 (60.6)	26
The nursing home is more short-staffed since the outbreak	56 (17)	274 (83)	49
The direct care workers that I work with went above and beyond their job requirements	38 (11.4)	295 (88.6)	46
During the height of worry about the pandemic, I never seemed to have enough time to get everything done on my job	127 (38.5)	203 (61.5)	49
At my job, direct care workers were provided with necessary personal protective equipment	21 (6.5)	300 (93.5)	58
I Received the appropriate training and support to be successful at my job during the COVID-19 outbreak	67 (20)	267 (80)	45
My workplace offered resources for emotional support to the staff	124 (37.5)	207 (62.5)	48
Overall I was satisfied with my job during the pandemic	80 (23.8)	256 (76.2)	43
My supervisor has been supportive of my need to take time off to care for a family member or myself	65 (19.6)	266 (80.4)	48
My supervisor helped me with job tasks if we were short	87 (26.4)	243 (73.6)	49
COVID-19 precautions had an impact on my relationship with the residents	116 (35.3)	212 (64.7)	51

their ability to provide residents with choice in their daily routines (75%). Approximately 89% of staff indicated that direct care workers went above and beyond their job requirements

While the pandemic has exacerbated barriers to PCC, there is also evidence that teams strengthened and grew as a result of shared experience. Staff felt that their supervisors were supportive of requests to take time off to care for family members or themselves (74%) and helped them with job tasks if they were short (80%). Further, 81% of staff agreed that managers treated them with respect and provided them with necessary resources including Personal Protective Equipment (94%), training and support (89%), and emotional support (62%). Despite the pandemic restrictions, 82% of staff stated that they were empowered to support residents in creative ways. Furthermore, 76% of staff still reported they were satisfied with their job.

Respondents highlighted efforts to combat social isolation of residents with 83% reporting that residents were able to stay in touch with family members virtually and 74% stating that residents and staff were encouraged to talk about their feelings regarding the pandemic. Interactions between residents remained a challenge. Sixty percent of staff reported that residents with no symptoms were able to interact with other residents while maintaining social distancing standards.

Discussion

Our research finds that the COVID-19 pandemic has exacerbated many existing challenges to delivering PCC and created new ones. We also find, however, a few silver linings in nursing home response to difficult conditions. In terms of challenges, we find that PCC in nursing homes was compromised by an exacerbation of existing problems such as staff shortage, burnout, and work overload, as highlighted by existing research (Brady et al., 2021; Husky et al., 2022; Serrano et al., 2021) and newly imposed COVID-19 related precautions which created additional anxieties and logistical difficulties that nursing homes were unprepared to face. For example, direct care workers are key actors of PCC practices, but job quality problems already facing direct care workers, such as low pay, few benefits, and heavy workloads mean that staff turnover is a consistent barrier to PCC (Kelly et al., 2020; Scales 2020). As such, these workers are already vulnerable to systemic inequality and poverty-related trauma. Notably, this finding could be a launching point for important future research exploring the full spectrum of mental and psychological harm, or trauma, that COVID-19 inflicted upon staff members in nursing homes.

In term of silver linings, perhaps the most surprising is the evidence of supportive practices despite pandemic-related conditions on nursing home staff and organizations. Given the extensive demands imposed by the pandemic, we might

expect that managers would also be overwhelmed and find it difficult to support workers. Contrary to that expectation, we found that most of the nursing home workers reported that supervisors were supportive and respectful of their contributions. Most workers reported that they were provided with personal protective equipment and even appropriate training on the job during the pandemic. More than half of the workers stated that they were provided with emotional and psychological support during the pandemic. Despite negative perceptions in the popular press, our findings indicate that the majority of staff felt supported by their supervisors in a variety of ways, an important factor necessary to support PCC practices. It is important to note that data were collected from March to July 2021, by that time, nursing homes may have overcome problems with supply and training experienced early on in the pandemic and began to develop practices to support teams of staff.

COVID-19–related precautions influenced the relationships and interaction between staff, family, and residents and made it more difficult to provide choice and autonomy in terms of in-person contact for residents with their families which is key to implementing PCC (Bhattacharyya et al., 2022). However, we found that the staff discovered a viable substitute for in-person interaction. For example, virtual technology was used to connect residents with their families. We find that an increased access to virtual communication, while not at all a full substitute for in-person interaction or care partner engagement (Kemp 2020), may continue to support connection for nursing home residents whose family and friends are more geographically dispersed. Further, we noticed an emphasis on relationship building between staff and residents, as residents were encouraged to share their feelings about the pandemic with staff members, and interact with other residents by practicing social distancing when they were asymptomatic. Staff also reported being empowered to find creative ways to improve care and quality of life for residents. These findings suggest that many nursing homes have been able to adapt to pandemic-related practices and identify creative opportunities to support PCC despite workload and staffing barriers.

This research is exploratory and was collected in one state at one point in time (March–July 2021). Thus, we cannot speak to the impact of the precautions in the early months of the pandemic or later as additional COVID-related fatigue has accumulated. Furthermore, COVID-19–related deaths and staff turnover may have resulted in a selection effect in our findings. Additionally, this study focuses on staff perceptions and may not adequately capture the experiences of residents and their family members. Finally, this report focusses on descriptive findings and we hope that future research will be able to tease out the complex relationship between COVID-19 precautions and PCC practices.

In conclusion, the nursing home staff experience of the COVID-19 pandemic has exacerbated existing challenges to PCC but has also resulted in a few promising practices as nursing homes work to support staff and residents. Future research should assess the relative impact of the factors that shape the barriers and facilitators to PCC practices over the course of the COVID-19 pandemic and the implications of the results for policy and practice in nursing homes in supporting staff to implement PCC.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Centers for Medicare and Medicaid Services [CMS], in partnership with the Georgia State Survey Agency, Georgia Department of Community Health, Healthcare Facility Regulation Division (CON 009319).

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