



The Experiences of Skilled Nursing Staff in Memory Care Units During the COVID-19
Pandemic

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By: Patricia Holmes, MOT/OTR

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Approved by:

Laura Santurri, PhD, MPH, CPH
Committee Chair

Heidi H. Ewen, PhD, FGSA, FAGHE
Committee Member

Sharon Baggett, PhD
Committee Member

Accepted by:

Laura Santurri, PhD, MPH, CPH
Director, DHSc Program
Chair, Interprofessional Health & Aging Studies
University of Indianapolis

Stephanie Kelly, PT, PhD
Dean, College of Health Sciences
University of Indianapolis

**The Experiences of Skilled Nursing Staff in Memory Care Units During the COVID-19
Pandemic**

Patricia Holmes

Department of Interprofessional Health and Aging Studies, University of Indianapolis

Abstract

Background: The novel coronavirus 2019 (COVID-19) resulted in the need for multiple mitigation strategies, including social distancing, quarantine, and consistent use of personal protective equipment. The impacts of these safety measures were felt more extremely by healthcare providers. **Purpose:** This qualitative study focused on the experiences of staff in skilled nursing facilities, specifically in locked memory care units, during the first year of the COVID-19 pandemic. **Method:** This study used a basic interpretive methodology, in which semi-structured, in-depth interviews were conducted with skilled nursing staff members who worked full or part-time in a locked memory care unit during the 2020 calendar year. Thematic analysis was used to organize and interpret the data. **Results:** A total of 11 participants provided data that resulted in themes around reasons for working on a locked memory care unit, experiences working with people who have behavioral and psychological symptoms due to dementia, training, outcomes of shared experiences, outcomes of policy changes, management support, and suggestions for a future pandemic. **Discussion:** The results of this study may have implications for skilled nursing facilities with locked memory care units that continue to grapple with the realities of providing care during a pandemic. Providing appropriate training, social support, and the appropriate protective equipment are among some of the suggestions.

Keywords: COVID-19, memory care, dementia, qualitative study, skilled nursing facility

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Table of Contents

| | |
|--|----|
| Abstract..... | 2 |
| Acknowledgments..... | 3 |
| Introduction..... | 8 |
| Problem Statement..... | 9 |
| Purpose Statement..... | 9 |
| Research Questions..... | 10 |
| Significance of the Study | 10 |
| Definition of Terms..... | 11 |
| Literature Review..... | 11 |
| Memory Care | 11 |
| Nursing Roles..... | 12 |
| Nursing Training..... | 12 |
| Nursing Experiences | 14 |
| Dementia..... | 16 |
| COVID-19 Effects on Skilled Nursing Care | 17 |
| Method..... | 20 |
| Study Design..... | 20 |
| Participants..... | 20 |
| Setting | 21 |
| Procedures..... | 21 |

| | |
|--|----|
| Sampling and Recruitment..... | 21 |
| Informed Consent..... | 23 |
| Data Collection | 24 |
| Data Management & Analysis | 25 |
| Rigor & Trustworthiness..... | 28 |
| Results..... | 28 |
| Reasons for Working on a Locked Memory Care Unit | 29 |
| Experiences Working with People Who Have BPSD..... | 30 |
| Training..... | 33 |
| Outcomes of Shared Experiences | 36 |
| Isolation Precautions | 36 |
| PPE Usage..... | 38 |
| Lockdown Procedures..... | 39 |
| Quality of Care..... | 39 |
| Outcomes of Policy Changes | 40 |
| Isolation Policies..... | 41 |
| Social Distancing Policies..... | 42 |
| PPE Policy Changes..... | 43 |
| Red Zone Policies | 46 |
| COVID Testing and Screening | 48 |

| | |
|--|----|
| Management Support | 48 |
| Communication..... | 49 |
| Provision of Supplies | 51 |
| Staff..... | 52 |
| Suggestions for Future Pandemic | 53 |
| Discussion | 59 |
| Reasons for Working on a Locked Memory Care Unit | 59 |
| Experiences Working with People Who Have BPSD..... | 60 |
| Training..... | 61 |
| Policy Changes..... | 63 |
| Support..... | 65 |
| Suggestions for the Future | 67 |
| Limitations | 68 |
| Future Implications for Research and Practice | 69 |
| Conclusion | 71 |
| References..... | 72 |
| Table 1 | 81 |
| Table 2 | 87 |

| | |
|-----------------|----|
| Appendix A..... | 88 |
| Appendix B..... | 89 |
| Appendix C..... | 94 |

The Experiences of Skilled Nursing Staff in Memory Care Units During the COVID-19 Pandemic

The COVID-19 pandemic profoundly affected the world, including the lives of many older adults. As of January 2022, there have been over 148,612 COVID-19 related resident deaths in nursing homes (Centers for Medicare and Medicaid Services, 2022). Nursing homes struggled to adapt to the guidelines and regulations recommended by the CDC (Cohen et al., 2020). Even in non-pandemic times, it is common for staff members of nursing homes to experience stress and burnout (Costello et al., 2018; Islam et al., 2017), often exacerbated by the lack of staffing in skilled nursing (Costello et al., 2018). As the COVID-19 pandemic spread, the lack of staff available to care for older adults continued to grow (Cohen et al., 2020). With less staff available to help care for the residents, further burden was thrust upon those staff members who chose to stay (Trabucchi & De Leo, 2020).

As the pandemic developed, nursing home staff also experienced challenges in providing the quality of care needed for their patients with dementia (PWD) (Abrams et al., 2020). The standard of care for people living with moderate to severe dementia before the COVID-19 pandemic included socializing with peers, consistent physical activity, and continued interaction with family and loved ones (Cohen et al., 2020; Greenberg et al., 2020). The COVID-19 pandemic forced many families and loved ones of people with dementia to limit or abstain from visiting (CDC, 2020a). Social distancing decreased the ability to continue a consistent physical activity schedule and eliminated the socialization components of care provided to skilled nursing facilities (Cohen et al., 2020). The unique changes to socialization experienced by staff and patients due to the COVID-19 pandemic have led to an increased risk of stress and burnout among skilled nursing staff in memory care units (Trabucchi & DeLeo, 2020). The burden of

providing socialization and engagement for PWD was placed on the nursing staff. This included certified nursing assistants (CNAs) and their supervisors, registered nurses (RNs), licensed practical nurses (LPNs), and qualified medical assistants (QMAs) who work at skilled nursing facilities (Cohen et al., 2020, Halifax, 2013).

Among other changes further burdening skilled nursing staff was the requirement to keep patients with dementia isolated in their rooms (Greenberg et al., 2017), which increased patient behavioral and psychological symptoms due to dementia (BPSD) (Arai et al., 2017). The decrease in structure and schedule within the patients' daily lives also increased the severity and consistency of BPSD (Greenberg et al., 2020). The disturbance in the patients' normal daily activities and the limited understanding of social distancing by patients with moderate to severe dementia increased the risk of BPSD for the patients (Greenberg et al., 2020).

Problem Statement

Common challenges for staff of skilled nursing (e.g., stress, burnout, and high turnover rates) (Costello et al., 2018) were compounded by the effects of the COVID-19 pandemic due to a severe drop in staffing, increased requirements for sanitation, and increased use of personal protective equipment (PPE) (CDC, 2020a). The feeling of being overextended and limited in providing quality care was further amplified in memory care units where the residents often experience BPSD (Arai et al., 2017; Greenberg et al., 2020). During these unprecedented times, the nursing staff's perceptions of memory care were vital in understanding how to better prepare for the next emergency.

Purpose Statement

The purpose of this basic interpretive study was to understand the experiences of skilled nursing staff who worked full or part-time in a memory care unit during the COVID-19

pandemic. Of specific focus were the potential strategies that could be implemented to improve the quality of care provided in locked memory care units during the next pandemic or similar emergency that would require quarantine or lock-down procedures for PWD.

Research Questions

This study addressed the following research questions:

- What are the experiences of skilled nursing staff employees who worked full or part-time in a memory care unit during the COVID-19 pandemic?
 - How did skilled nursing staff members perceive their training in preparing them for the realities of a pandemic?
 - How did skilled nursing staff in memory care perceive the support provided to them by management during the pandemic?
 - How did skilled nursing staff members perceive the changes (policy and otherwise) enacted during this pandemic, and how did those changes affect the quality of care provided to memory care patients?
 - What strategies were implemented by skilled nursing staff in memory care that helped improve the quality of care?

Significance of the Study

The results of this study will inform the training and support provided to skilled nursing staff in memory care units, specifically focused training on how to cope with the next pandemic or similar emergency that affects how we provide care to PWD. Documenting the experiences in this pandemic can help improve nursing homes' responses to future crises (Stall et al., 2020). It may also lead to improvements in the strategies used to address the challenge of providing care

during a pandemic or other similar emergency that could require quarantine or lock-down procedures for PWD.

Definition of Terms

- Skilled nursing facility: A skilled nursing facility is a typical nursing home that provides a full range of clinical long-term care services, from skilled nursing care to rehabilitation and assistance with activities of daily living (Shi & Singh, 2017).
- Memory care unit: Memory care units (MCUs) are secure wings or sections of a long-term care facility, either within an assisted living or skilled nursing facility. The design of MCUs requires specialized knowledge, professional experience, person-centered approaches, and careful consideration of the residents' lifestyles and changes in both health and behavior (Ferodous, 2019).
- Dementia: Dementia features a change in memory functioning and at least one other cognitive disorder such as a decline in speech, difficulty interpreting sensations, a decline in motor functions, or a disturbance in executive functioning (Pelletier & Landreville, 2007).
- Moderate to severe dementia: Identified as a score of greater than two on the Clinical Dementia Rating Scale (CDR) (Mjørud et al., 2017).

Literature Review

Memory Care

Within the long-term care continuum are special wards, called memory care units, designed for the care and safety of PWD (Hughes, 2001; Manthorpe & Samsi, 2016). Memory care units are separate areas or halls within a skilled nursing facility specializing in caring for people living with dementia and other cognitive impairments (Ferdous, 2019). These units often

have specialized activities and nursing staff trained to provide care specifically for people living with moderate to severe dementia (Ferdous, 2019). People living with moderate to severe dementia have demonstrated improved activity participation and decreased agitation when living in smaller units (Chaudhury et al., 2018). The staff are typically trained in the prognosis and progression of dementia, communication techniques, and care techniques (Ehlman et al., 2018; Takizawa et al., 2017). The strategies learned in these training programs provide a better understanding of the people being served by these staff members and improve their ability to cope with the changing behavioral and psychological symptoms of dementia (BPSD) (Ehlman et al., 2018).

Nursing Roles

Certified nursing assistants (CNAs) provide daily care for patients in skilled nursing facilities (Halifax, 2013). They report directly to the nurse working their hall or unit, typically LPNs or QMAs (Halifax, 2013). The nursing staff who work in memory care units have reported that they find joy in establishing relationships with the people with whom it can be challenging to connect (Coates et al., 2016). These staff members stated that they find value in making their patients smile and helping them find joy in their day. Skilled nursing staff who work with people living with dementia often report that they work in this setting because they have a passion for providing care to the vulnerable population of PWD (Coates et al., 2016). Unfortunately, many of these staff members also experience stress, burnout, and in the end, high turnover rates (Coates et al., 2016; Tilden et al., 2012).

Nursing Training

The training provided to nursing staff can be extensive for some and limited for others, depending on the level of license or certification acquired. Certified nursing assistants (CNA) are

typically provided a four to eight-week training period (American Red Cross, 2022). Licensed Practical Nurses (LPN) typically complete a one-year degree or certificate at a technical school (U.S. Bureau of Labor Statistics, 2022). A Qualified Medication Aide (QMA) is a CNA who has passed the state requirements to administer medications (Indiana Department of Health, 2022). This training is typically 100 hours and supervised directly by a licensed nurse (Indiana Department of Health, 2022).

Nurses have not been provided much education regarding preparedness for a pandemic (Fernandes et al., 2021). The education or training nursing students have been provided has since been found lacking for the realities of the COVID-19 pandemic (Fernandes et al., 2021). Nurses and nursing staff are typically educated on precautions for other infectious diseases such as C-diff (Crogan & Evans, 2007). New graduate nurses found themselves often severely unprepared for the realities of the COVID-19 pandemic (Sarnkhaowkhom et al., 2021). Nursing staff are often aware of the benefits of vaccination, isolating when feeling sick, and wearing PPE such as masks (Aiello et al., 2011). Unfortunately, the use of this knowledge has been limited with working nursing staff members (Aiello et al., 2011).

Nurses and nursing assistants are often trained in dementia care; however, it is not always sufficient when providing care to people with BPSD (Ehlman et al., 2018). Islam and associates (2017) also found that nursing staff in long-term care facilities could benefit from improved training on caring for PWD. Nurses are educated on how to react to BPSD; however, it is often presented in an ideal situation, lacking the unpredictability of a real-life situation (Ostaszkievicz et al., 2015), such as a global pandemic.

Infection control is often one of the first things nurses are trained on, however the primary aspects of this training, such as hand washing, staying home if you are ill, and utilizing

PPE are often forgotten (American Nurses Association, 2022). Nursing homes have demonstrated a significant lack in the appropriate training and preparedness for the realities of COVID-19 (Fernandes et al., 2021). King and associates (2021) found that nursing assistants felt their training was lacking in preparing them to provide care throughout the COVID-19 pandemic.

Nursing Experiences

Nursing staff in skilled nursing facilities have experienced stress and burnout for many years (Halifax, 2013; Islam et al., 2017; Tilden et al., 2012; Van Bogaert et al., 2017; Vander et al., 2016; Woodhead et al., 2016). The concept of stress in this population is not new and has been rigorously studied. Many of these studies have helped improve the understanding of what aspects of providing care in this specific setting increase stress and burnout for this population.

Nursing staff has experienced increased psychological demand compared to managers (Islam et al., 2017). A lack of support from management was noted to increase the risk of burnout in long-term care staff (Woodhead et al., 2016). Limited social support from management and the shortage of nursing staff increased the feeling of compassion fatigue (Anderson et al., 2010; Stenheiser, 2018). Compassion fatigue is the experience of losing the ability to feel sympathy due to the emotional exhaustion experienced from providing repeated care to those who are ill and suffering (Stenheiser, 2018). Compassion fatigue was identified by Steinheiser (2018) as a predictor of burnout among nursing staff. In a study by Woodhead et al. (2016), nursing staff's high job stress in long-term care was associated with increased depersonalization levels, emotional exhaustion, and a decreased feeling of personal accomplishment. These stress components have often led to staff burnout and turnover (Tilden et al., 2012).

Research has shown that social support systems decrease the risk of burnout; specifically, supervisors' support decreased the emotional exhaustion reported by nursing staff (Anderson et al., 2010). Liu et al. (2020) found that caregivers with more social support reported less burnout. Greater schedule autonomy has also been shown to decrease the risk of burnout (Vander et al., 2016). Recognizing the need for personal accomplishment and independence at work can help reduce burnout and stress for nurses (Vander et al., 2016). Woodhead et al. (2016) also found that personal stress could play a role in the risk of burnout, although it was not directly related. Occupational stress continues to be the primary factor leading to burnout among nursing staff in long-term care.

Nursing staff in long-term care facilities have often experienced increased anxiety and depression (Costello et al., 2019). These nursing staff members are expected to provide an excellent level of care that is difficult to achieve in the time allotted (Steinheiser, 2018). Vander and associates (2016) identified workload and working hours as positively related to burnout. Islam et al. (2017) found that nursing home staff experience increased stress in larger facilities. An increase in the number of beds a nursing staff member cared for correlated with increased time pressure and feelings of stress. In smaller, group-home settings, home health reported less stress among the nursing staff and a better relationship between the staff members and the patients they served. Woodhead et al. (2016) found that job demands increased the risk of burnout, and an increase in resources, such as social support from supervisors, family, and friends, did not lower the risk of burnout.

Providing care to patients with dementia can be a significant challenge (Liu et al., 2020). A study by Liu et al. (2020) found that symptoms of delusions, anxiety and abnormal behavior have the most significant adverse effect on caregivers for PWD. Nursing staff who have been

trained to provide a positive approach to care have reported increased confidence working with PWD and increased job satisfaction (Ehlman et al., 2018). A positive approach to care focuses on the abilities retained by the individual and decreases the focus of care on what skills the patient has lost (Ehlman et al., 2018). A positive approach when treating PWD has been shown to improve the quality of care provided (Islam et al., 2017). This positive approach to treating PWD is often a part of the training for nursing staff members in long-term care facilities (Islam et al., 2017).

Dementia

Over 50 percent of residents in nursing homes and assisted living facilities have some form of dementia or cognitive impairment (Alzheimer's Association, 2007). The prevalence of resident impairment in these settings is growing ever more critical. It is estimated that 5.8 million Americans live with Alzheimer's dementia as of 2019 (Alzheimer's Association, 2019).

Alzheimer's dementia, like other forms of dementia, is a form of progressive neurodegenerative disease that affects not just a person's memory but also how a person walks, dresses, eats, reacts to stressful situations, and even recognizes pain (Alzheimer's Association, 2019).

Common symptoms experienced by PWD include behavioral and psychological symptoms of dementia (BPSD) (Arai et al., 2017). These symptoms include agitation or aggression, irritability or lability, apathy, delusions, and anxiety. Agitation or aggression were the most prevalent behaviors for PWD diagnosed with moderate to severe dementia. Verbal agitation behaviors were the most significant behavior that demonstrated an increase due to pain or discomfort (Pelletier & Landerville, 2007). Staff members experienced an increase in BPSD when PWD experienced pain (Halifax, 2014) or other types of discomfort, such as needing assistance with toileting (Ostaszkievicz et al., 2015).

In a study by Arai et al. (2017), 64.1% of participants experienced at least one BPSD. Pelletier and Landerville (2007) found that patients with moderate to severe dementia often express discomfort through varied behavior. Residents who had complicated relationships with other residents or isolated themselves seemed to demonstrate an increase in problem behaviors compared to their peers (Arai et al., 2017). Nursing staff knows that PWD often use BPSD to communicate their needs (Ostaszkievicz et al., 2015). Nursing staff has stated that these behaviors are most experienced when physically assisting patients with activities of daily living (ADLs) (Ostaszkievicz et al., 2015). If the resident demonstrated a high level of need in ADLs but was not significantly cognitively impaired, they exhibited increased BPSD (Arai et al., 2017). Vice versa, those who were severely cognitively impaired but demonstrated a high level of independence in ADLs also experienced an increase in BPSD (Arai et al., 2017). Nursing staff members of long-term care facilities are often asked to interpret their patients' behaviors to predict the patient's needs; however, with limited training, staff can experience increased burnout (Halifax, 2013).

COVID-19 Effects on Skilled Nursing Care

The novel coronavirus disease 2019 (COVID-19) emerged in China in late 2019 (Kaiser Family Foundation, 2020). The World Health Organization declared the COVID-19 virus a global pandemic in March of 2020 (Kaiser Family Foundation, 2020). As the number of positive COVID-19 cases grew throughout the United States, it was clear that nursing home residents were affected more than any other population (Grabowski & Mor, 2020). Indiana reported 55% of the state's total COVID-19 deaths had occurred in long-term care facilities as of October 2020 (Kaiser Family Foundation, 2020). COVID-19 has claimed the lives of over 200,000 residents and staff members in long-term care facilities since February of 2022 (Chidambaram, 2022).

Abrams and associates (2020) found that larger nursing homes in an urban setting had a more significant percentage of African-American residents who experienced more COVID-19 positive cases. As the numbers of COVID-19 patients continued to climb, the need to protect skilled nursing facilities' residents increased. The effects of quarantining and social distancing put a strain on many, but it significantly impacted those living with dementia and the people who care for them (Cohen et al., 2020). Extended periods of quarantine, ten days or more, have been known to cause symptoms of post-traumatic stress disorder, avoidance behaviors, and anger (Brooks et al., 2020).

Cohen and associates (2020) conducted a study focusing on the effects of quarantine and social distancing during the COVID-19 pandemic for PWD living at home with their caregivers. They found that PWD experienced increased anxiety throughout the pandemic. The study found some PWD also required an increase in antipsychotics and benzodiazepines during the pandemic, suggesting the pandemic worsened the behaviors, such as anxiety, agitation, and delusions often experienced with dementia. This often resulted in participants reporting increased use of antipsychotics and benzodiazepines. Cohen and associates also found that 90% of the participants had to stop participating in all therapies or physical activity outside the home. In addition, the caregivers of people with moderate to severe dementia were noted to experience higher burden levels after four weeks of quarantine (Cohen et al., 2020). Many caregivers were forced to limit or completely stop visiting their loved ones, while paid caregivers were also limited due to the high demand (Cohen et al., 2020).

The restrictions implemented during the COVID-19 outbreak highlighted caregivers of PWD daily stressors and the needs of these caregivers (Greenberg et al., 2020). Older adults have been at a higher risk of contracting COVID-19, which increased the need for strict restrictions in

physical contact with others (Centers for Disease Control and Prevention, 2020). The CDC recommended nursing homes restrict visits from outside vendors, eliminate in-person visits with family members of residents, and required the residents to remain in their rooms, isolated from one another. These isolating restrictions caused an increase in the behaviors experienced by people living with dementia, especially those with moderate to severe dementia (Cohen et al., 2020; Greenberg et al., 2020; Whiting et al., 2021).

Trabucci and De Leo (2020) compared nursing homes in northern Italy to besieged castles. The results of this study highlighted the loneliness among older adults living in skilled nursing facilities as they were suddenly unable to touch or see their loved ones. In addition, the staff in these nursing homes experienced a feeling of hopelessness as they were met with the challenges of limited supplies for protecting themselves from the virus and the supplies needed to provide basic care for their patients (Trabucci & De Leo, 2020).

There is limited research on the effects of this pandemic on locked memory care units. To better understand the experiences of the staff working in these extreme situations needs to be examined. To better understand how to care for PWD who have been affected by this global pandemic. The population within many locked memory care units includes a higher number of individuals with moderate to severe dementia, and often these individuals experience an increase in problem behaviors. The risk of stress and burnout among these staff members is likely. Studying these skilled nursing staff members' experiences during this unique time is crucial in better understanding the effects of dementia and the need for further training and preparedness for skilled nursing staff.

Method

Study Design

The primary researcher used a basic interpretive methodology to explore the experiences of skilled nursing staff working in specialized memory care units during the COVID-19 pandemic. A basic interpretive approach focuses on individuals' experiences, attitudes towards a phenomenon, and how they may adjust to changes due to the phenomenon (Merriam, 2002). In this study, semi-structured, in-depth interviews were used to collect data about the phenomenon of the COVID-19 pandemic and how it affected individuals working in locked memory care units. Approvals from the Institutional Review Board (IRB) at the University of Indianapolis, and the healthcare provider organization at which the primary researcher was employed, were obtained before study activities began.

Participants

Inclusion criteria for this study included being a skilled nursing staff member with a CNA certification, LPN license, QMA license, or an RN license and having worked full or part-time (a minimum of 20 hours a week) in a locked memory care unit from January 2020 through December 2020. Including skilled nursing staff who worked during this time frame captures the experiences both before and during the COVID-19 pandemic. As all study activities were conducted in English, staff members who did not identify English as the primary language they conversed with at work were excluded from this study. Staff members who work the night shift, typically between 9:00 p.m. and 7:00 a.m., were not eligible for this study as they generally worked while the residents were asleep. These staff members were excluded as they are less likely to interact with the residents or experience BPSD.

Setting

The setting for this study included multiple facilities associated with a skilled nursing facility corporate company located in Indiana. Fourteen facilities were contacted for participation. These fourteen facilities had a specialized locked unit, or a unit separated from the facility's general population. These units are specialized in providing care to individuals who have moderate to severe dementia. The staff members are trained and familiar with PWD who exhibit up to one BPSD. Participants were also recruited through social media, and these individuals resided in Ohio, North Carolina, and southern Indiana.

Procedures***Sampling and Recruitment***

Convenience and purposive sampling were utilized for this study, recruiting staff members from the company the primary researcher works for and from social media outreach. Participants were accepted based on the types of facilities they work in and their credentials and experiences working in locked memory care units that provide care for PWD. Malterud et al. (2015) provide criteria that can assist qualitative researchers in determining a sample size that will result in adequate information power. Information power refers to the strength of a qualitative study and is influenced by five different components: study aim, sample specificity, use of an established theory, quality of dialogue, and analysis strategy (Malterud et al., 2015). A narrow study aim focused on the experiences of a specific population providing care in an area of skilled nursing that is common, but not present in all skilled nursing facilities, suggests a small sample size would be needed. The sample population of this study was also narrow, focused on a small subset of individuals affected by a broadly affecting phenomenon. No specific theory was used to develop this study; this lack of structure would suggest a larger sample size would be

needed to reach information saturation, otherwise known as information power by Malterud et al. (2015). Experienced qualitative researchers assisted with editing the interview guide to help ensure that the communication between the primary researcher and the participants was clear and addressed the study's research questions. The primary researcher also had hands-on experience working with this population throughout this unprecedented time which increased their ability to empathize and relate to the participants' experiences. This unique ability to have a quality dialogue with the participants would suggest the need for a smaller sample size. The analysis strategy for this study focused on a cross-case strategy, utilizing the different experiences to provide a comprehensive analysis of the subject. As suggested by Malterud et al. (2015), a narrow study aim, specific population sample, and strong dialogue would suggest a smaller sample size would be sufficient. However, the lack of a theory and the use of a cross-case analysis suggests increasing the sample size (Malterud et al., 2015). It was determined by the primary researcher and committee members that a sample size of ten to fifteen participants would be sufficient to reach information power.

First, a letter of cooperation was requested from the administrators from each facility. Once cooperation was established, an email was sent to each facility with the Administrator, Director of Nursing, and/or Unit Manager of the locked memory care unit copied. This email provided information regarding the aim of the study and recruitment language that was to be used by the Unit Manager and Director of Nursing when sending emails to potential participants. The recruitment language also assured all parties that participation in this study was voluntary. An electronic copy of the recruitment flyer (Appendix A) was provided with a request that it be attached to emails to potential participants, as well as recommendations for where it could be posted in the facility. Multiple hard copies of the recruitment flyer were mailed to each facility.

This primary researcher offered to provide additional information about the study via virtual or phone conference.

While contacting individual facilities did yield good participants for the study, it was not enough to reach a sample size needed to reach a sufficient level of information power. Given that, a second method of recruitment involving social media outreach was utilized later in the study to broaden the scope of potential interviewees. Facebook posts were made on the primary researcher's main feed with the recruitment flyer used in the post. Facebook group administrators were also contacted via a direct message through Facebook to obtain approval to post recruitment material in their group. Facebook groups that were contacted included ones that focused on nursing staff in long-term care, memory care facilitators, activities directors in locked memory care, and certified nursing assistants in long-term care. Once approval was obtained, the recruitment flyer was utilized to complete the post. Participants were then able to message the primary researcher through Facebook or text message directly.

Informed Consent

The recruitment flyer instructed individuals interested in participating to contact the primary researcher. At the time of the initial phone call, the primary researcher explained the intent of the study and what participation involved (i.e., a 45 to 60-minute interview and a brief follow-up post-interview). The participant was informed that their participation in this interview could help shape the future in which we care for PWD during a pandemic. It was emphasized that participants could not participate while on the clock, the company they work for was not associated with this study, and participation in this study would not affect their position. Confidentiality was also explained. The participants were informed that any information they provided would be de-identified before analysis and publication, and the name of the company

and facility for which they work would not be included. If the individual was still interested in participating, an interview was then scheduled at a date and time that was convenient for both the interviewer and the participant. Before the interview, the primary researcher emailed, mailed, or hand-delivered the study information sheet to the participant. At the start of the interview, the participant was given the opportunity to ask questions about the study information sheet. Verbal consent to participate was obtained before the interview began.

Data Collection

The interview took place via a phone call at an agreed-upon date and time between the primary researcher and the participant. This phone call followed the appropriate precautions regarding the spread of COVID-19, with no physical contact occurring between the two parties. The interviews lasted 29 to 68 minutes. The interviews were recorded using a digital audio recording device, and notes were taken on a computer during the interview. The audio recording device was a deactivated cell phone owned by the primary researcher and was password-protected.

Interviews were conducted using a semi-structured interview guide (Appendix B). Interview questions were open-ended, focusing on the experiences of the staff members during the COVID-19 pandemic. The topic of questions included the staff member's experiences before the COVID-19 pandemic regarding care for PWD and those who experienced BPSD. The questions also focused on the changes experienced by these staff members after the COVID-19 pandemic affected the facilities in which they worked. The interview guide was collaboratively developed with the assistance of the research committee for this project. Committee members reviewed and provided input regarding the style and subject of the questions. Open-ended questions within the interview guide helped to elicit responses specific to the individual and their

experience without the influence of the primary researcher's own opinions or experiences. Interview questions focused on following the interviewing style utilized by Tisdell (2002). The interviewer began the interview by sharing personal information regarding their experience providing care to individuals in locked memory care units before and during the COVID-19 pandemic. This helped alleviate the risk of "othering" discussed by Tisdell (2002) and allowed for a more open conversation. This provision of personal information can also serve as an ice breaker, which has been recommended by Creswell (2014).

Data Management & Analysis

Once an interview was completed, the audio recording was uploaded to a password-protected computer. It was transcribed verbatim through the transcription service Temi©. At that time, the audio recording was deleted from the digital audio recording device. The primary researcher de-identified each transcript and assessed its accuracy before uploading it to Dedoose (8.3.35©), which was used for data management and analysis.

A thematic analysis of the data was used as recommended by Vaismoradi and associates (2013) to help organize the codes and discover themes within the data. The first step recommended by Vaismoradi and associates (2013) is to become familiar with the data. The primary researcher reviewed the audio recording and notes within 48 hours of the initial interview to immerse the primary researcher in the data.

The primary researcher made notes based on the first impressions of each interview during the initial review of the transcripts to help begin developing codes (Hsieh & Shannon, 2002). Generating initial codes is the second step in thematic analysis (Vaismoradi et al., 2013). Codes are used to "winnow" information as the interviews are analyzed (Creswell, 2014). The primary researcher and an analysis expert with extensive experience in qualitative data analysis

reviewed the same transcript individually and compared codes. The codes identified between the primary researcher and analysis expert helped build an initial set of codes that would eventually become a codebook. Throughout the coding process, the codebook was added to and reorganized to allow for a more inclusive analysis, allowing the different experiences of participants to be clearly identified. As the interviews were completed and transcribed, the codebook was utilized to evaluate and define the data gathered. After all the interviews were coded initially, the primary researcher reviewed earlier transcripts to ensure the newer codes were applied appropriately.

The third step in thematic analysis is searching for themes (Vaismoradi et al., 2013). Codes were organized to begin identifying categories of data. The categories that emerged through the initial analysis process were further reviewed and organized to identify overarching themes (Vaismoradi et al., 2013). This analysis process helped to interpret common threads among interviews and find themes that helped explain the experiences within the phenomenon (Vaismoradi et al., 2013).

The fourth step of thematic analysis involves reviewing the themes in relation to the entire data set, this is referred to as cross-case analysis. Throughout this fourth step of the analysis, the themes identified in the prior step are further organized and categorized in relation to all other interviews. This process helps to better organize and define the findings (Hsieh & Shannon, 2002). During this step of the analysis, member checking was utilized to ensure the emerging findings accurately reflected the participants' stories. As recommended by Creswell (2014), each participant who agreed to a member checking interview was emailed an overview of the primary researcher's interpretations of the full study results with a breakdown and definition of the themes (Appendix C). A table was also provided to increase the ease with which participants could understand the themes identified (Table 1). Another phone conversation was

scheduled with each participant to review the emailed transcript with identified themes. All the participants were contacted via text message or Facebook messenger to participate in the member checking interviews. Three participants responded with the initial message sent. After a second attempt to contact those who did not respond one more participant did respond. In total, four participants completed a member checking interview. A third attempt to contact participants who had not responded was conducted with no further response. Although there was a limited response to member checking the generalized agreement of the participants would suggest the analysis was able to capture their experiences sufficiently (Birt et al., 2016), suggesting the study was able to accomplish information power (Malterud et al., 2015).

After the results were reviewed, the participant was asked a few short questions regarding the themes identified. The participant was asked if they agreed with the themes identified and if they accurately reflected their experience. They were also asked if they believed the identified themes captured enough of their experience to represent them appropriately. The member checking interviews lasted 26 minutes to 14 minutes. The participants agreed the interpretation of the data reflected their general experience, with some additions to their experiences as they have evolved over the changing circumstances such as improved training.

As identified by Vaismoradi et al. (2013), the final two steps of thematic analysis begin with defining the themes to organize better the story of the narratives told within the interviews. This organization should create clusters of themes, 10-15 ideally, that help generate the full story being told by the study. This study identified 7 categories of themes initially. With further analysis and organization of the data, seven primary clusters of themes were defined with 12 subcategories of themes. Finally, this produced a report that provides a vivid and compelling analysis of the experiences researched within this study.

Rigor & Trustworthiness

Henderson and Rheault (2004) recommend using the Rosalind Franklin Qualitative Research Appraisal Instrument (RF-QRA) to assess the trustworthiness of qualitative research. The RF-QRA focuses on four concepts to address study rigor: credibility, transferability, dependability, and confirmability. Member checking is one method of ensuring credibility within the research (Henderson & Rheault, 2004). The primary researcher and the research committee's analysis expert completed an individual analysis of one interview transcript and compared codes to ensure the transferability of codes when creating a codebook. The primary researcher also kept a field journal throughout the process of interviewing participants to improve the credibility of the research by assessing the primary researcher's perceptions of the experience (Henderson & Rheault, 2004). The interviews were conducted with nursing staff members located throughout Indiana, as well as Ohio and North Carolina. The experiences of these staff members would likely differ as each state, city, or county was affected differently by the pandemic. The different experiences in how the facilities responded to the COVID-19 pandemic provided a broader view of the participants' experiences, increasing the study's transferability (Henderson & Rheault, 2004). Confirmability was attempted through feedback from committee members throughout research design and data collection, management, and analysis (Henderson & Rheault, 2004).

Results

This basic interpretive qualitative study sought to understand the experiences of skilled nursing staff who worked in a memory care unit during the COVID-19 pandemic. A convenience and purposive sample resulted in 11 participants. There were eight CNAs, three LPNs, one QMA, and two RNs (Table 2). Participants ranged from two years to 28 years of experience working in long-term care. These participants provided insight into their experiences providing

care for a notoriously difficult population during an unprecedented time in history. The participants provided potential strategies that could be implemented to improve the quality of care provided in locked memory care units during the next pandemic or similar emergency that would require quarantine or lock-down procedures for PWD.

Themes were developed throughout the interview and analysis process. The themes identified included reasons for working on a locked memory care unit, experiences working with people who have BPSD, training, outcomes of shared experiences, outcomes of policy changes, management support, and suggestions for a future pandemic.

Reasons for Working on a Locked Memory Care Unit

The interview participants identified multiple reasons for choosing to work in a locked memory care unit. A love for the patients they treat, specifically those with dementia, the unique nature of this population, and experience with a family member who had dementia were the primary reasons named for working with PWD. The majority stated they love the residents as the primary reason they decided to work with PWD.

I mean, dementia patients kind of have a special place in my heart. A lot of people don't understand dementia patients and I really like to try to implement the things that I know and to try to improve their quality of life. My main reason for long-term care in general is because, I mean, nobody wants to be away from home and I feel really strongly about families being comfortable with their loved ones, not being at home and vice versa. I liked developing those long-term relationships and kind of becoming those patients' families. (Participant 4)

This sentiment was further reflected by another participant.

I have a love for the dementia and feel that they should receive the same exact care that those outside the locked unit receive. And, I just have, I have a passion for working with them and just working with their mental status and, making sure they have the greatest quality of life that they can get. (Participant 1)

The unique nature of this population was also a common theme. “I feel like they're an even more vulnerable population and they just need, that extra care. I just always felt drawn to, those extra vulnerable people, so that's why I do it” (Participant 7). A few of those interviewed stated they had family members who had dementia, creating a desire to work with and help individuals with moderate to severe dementia. “My grandmother and my grandfather passed away of dementia, and I have helped them, helped my aunt and uncles and my mother, care for them. And I've just been interested in it ever since” (Participant 9). Many reasons were named for why these participants chose to work with PWD, but it would appear the main reason is general caring and empathy for the people and their families.

Experiences Working with People Who Have BPSD

Many participants stated that it was challenging to work with PWD who experienced BPSD. Participants experienced emotional fatigue working with PWD, with some experiencing physical injury. Some participants also stated that behaviors appeared to change with a COVID-19 diagnosis. Participants said they experienced an increase in BPSD when residents had COVID-19, while others experienced a decline in behaviors. Many participants stated that it was challenging to provide care to PWD while wearing masks, gowns, or face shields as this often-increased behaviors.

Working on a locked unit can be emotionally draining. Participants often stated that emotional fatigue was common prior to the pandemic when working with PWD who experienced BPSD.

It's frustrating and it's really, I think really sad because I feel like a lot of, especially in early dementia, those patients know that something's not right and it's so hard for them to understand what's happening or even they know what's happening. We do have a lot of behaviors. We do have a lot of patients that become aggressive. I'm not a firm, you know, I'm not a believer in let's just medicate or sedate somebody. I think you have to try to work through that. And I think, you know, it's hard, it's hard. (Participant 4)

Some participants experienced a personal injury while working with this population.

Oh my, I could write a book. I could write a whole novel, the size of a dictionary. We've been beaten, smacked, kicked, spit on, peed on. This one girl that I worked with, she got pushed up against a dresser by an end-stage Huntington's patient with dementia. She ended up with a TBI. (Participant 11)

Before the COVID-19 pandemic, a few participants noted less severe behaviors.

Prior to the pandemic, I don't feel like even if they had agitation and whatnot, I don't feel like they were that bad prior to the pandemic. Because they were, like I said, they were able to still see family and they were able to go outside to the courtyard. (Participant 3)

However, it was also stated that behaviors were common and did increase the difficulty of working with these individuals.

So, verbal aggression, for sure. Just, you know, everyday. I mean, some of it is just a repetitive tick that they have, like where they'll just curse or call names, but sometimes it's just, based on the care when we're trying to give them some medication, or give them

something to eat, or it's mostly, during ADL care. You know, you are trying to change them or give them a shower. (Participant 7)

Participants expressed that COVID symptoms changed the residents' behaviors. For example, some participants stated that residents' behaviors decreased as the residents began feeling unwell. "When they were like sick, sick with COVID, they didn't get up and wander. They were, you know, laying in the bed, red in the face on oxygen sick" (Participant 11). While others said symptoms seemed to increase the agitation in residents. "Behaviors got a lot worse. Especially the residents that actually did have COVID. They were really agitated about a lot of stuff. Compared to the residents that were in the yellow zone" (Participant 5). Participants also identified that it was difficult for the residents to understand what was going on, which often increased behaviors.

You're asking how they reacted to isolation? Oh, that was non-existent on my unit. We did our best and the ones that like, could understand. There were only probably I want to say there's only probably two, maybe three on my unit of 25 that could like fully understand that they needed to stay in their room or wear a mask or do anything all the rest of them were just gone. So, they had no sense of isolation at all. They were just wandering around. We were doing our best to social distance, isolate. There was none. (Participant 11)

Participants discussed the psychosocial effects of working with this population. Many stated that behaviors are usually triggered by changes in the environment or the provision of care by staff.

And some of them will never be ready to take a shower. So, you have (to be), like, "Well, we're going to go in there and we're going to get it done." So, that's when the

combativeness will come in. I mean I always think of what would you do if you just didn't really know what was going on? You don't remember the people from day to day that are coming at you and taking your clothes off, especially putting water on you, you know, in a room that the shower rooms are never like a bathroom at home. It's like, it's a shower room. So, it's very bright lights clinical. It can be cold you know if the heater hasn't been on long enough. I mean, it's just a lot of sensory attack on top of modesty issues that are deeply ingrained. That's when the combativeness, actual physical aggression usually comes out at those times. I've been hit so many times. But it's whatever you know. (Participant 7)

Knowing the individual resident's history or preferences helped alleviate behaviors before and during the pandemic.

So, obviously, you're going to have all that on a memory care unit and honestly, I just feel like it's all about the approach. Your body language and the tone that you use when you're speaking to them. Being able to keep yourself cool headed at all times. Know that there will be behaviors. (Participant 8)

Training

Participants were asked to discuss their education and training related to multiple facets of working on a locked memory care unit. The interview guide focused on the training received addressing dementia training, hand hygiene, isolation precautions, lockdown procedures, and PPE procedures.

Most participants stated that they did not receive any specific training required to work on a locked unit.

I just train normally like a CNA. Nobody really taught us how to take on the residents.

So, I mean, it just was like, from being in a locked unit, so many times you just learn the residents and learn their behavior, so you know what to do. But other than that, my personal training, we didn't learn nothing like special about how to take care of the residents that's on a locked unit. Like we didn't learn any of it. (Participant 2)

However, many said they had received dementia education through online in-services provided to all employees at the facility where they work.

I done a couple of the, Relias. I don't know if you know what that is. It's like the learning program that my job offers. I don't know if it's like other places or anything like that, but we did, I done a few certifications on there. (Participant 6)

Many participants stated they learned from other staff members how to approach residents with dementia. "Our facility didn't really give us a lot of training. In the beginning the other staff kind of just teach you like what they know" (Participant 11). Some participants stated they elected to receive specialized dementia training, which could range from four hours to 100 hours.

I did do some classes that were, it was the personal classes that my facility paid for. And I also went to a "Communicating with Dementia Seminar." So, that was, they did the virtual dementia tour when you do the glasses, like the goggles and the gloves. It's pretty popular now. And so, I did that, but then it wasn't really required of me, but it was paid for, so I wanted to learn everything that I could. (Participant 7)

After member checking was completed two participants did state that they had since received better training on providing care to patients with dementia. "After COVID I took the dementia certification class. Well, I mean COVID isn't over" (Participant 3).

Many participants stated hand hygiene, isolation precautions, and PPE procedures were included in their training to gain their credentials. A few participants also mentioned hand hygiene and PPE procedures were addressed with regular in-service training provided through their employer. “I had training, in my CNA class, they don't really go over like the training once you get in a nursing home, but they do have Relias, or in-services that we have to sign on” (Participant 2).

Training in lockdown procedures was not common before the pandemic, leaving many participants unprepared for the COVID-19 experience. “Big fat, zero, zero, literally. Nothing could have prepared us for what, you know, hellfire came down with COVID.” (Participant 11) While some participants mentioned they did receive training regarding the potential for the facility to be on lockdown if there was an active shooter or bad weather, most participants stated they received little to no training focused on lockdown procedures.

That actually surprisingly until probably the last four years was not ever a huge topic. I would say probably four years ago we started having to do more emergency preparedness. I think just the way society is now these days, kind of brought some of that to light. So, we would have, I had been a part of an emergency preparedness committee in Johnson County where we would prepare for floods, active shooters, bad weather.

That's part of annual training as well, but it probably did become more like quarterly training. And the last four years it's been more frequent. (Participant 4)

As a result, most interview participants said they were not prepared for the realities of COVID-19 lockdown procedures. These procedures included limited to no visitations from family and friends and limited or no outings for the residents. “Not prepared at all? This was actually the

first time in my whole career that I've had to deal with any kind of precautions that we've had to deal with, with COVID” (Participant 8).

Outcomes of Shared Experiences

Participants had multiple changes they experienced while working on locked memory care units before and during the pandemic. These changes helped shape the experiences these individuals had working in this environment before the world changed due to a global pandemic. These experiences have been organized into isolation precautions, PPE usage, and lockdown procedures. Isolation precautions focus on the participants’ experiences with the changing expectations and needs following procedures focused on isolating patients in their rooms or from other patients. PPE usage focus on the increased use of PPE and how it affected how the participants provided care to their patients. Lockdown procedures were a new phenomenon that participants had to navigate when providing care to their patients. Quality of care also changed as things changed throughout the pandemic, and this became increasingly difficult for the participants to work through.

Isolation Precautions

Before the COVID-19 pandemic, participants said isolation precautions were rarely used, but when they were, this was usually due to MRSA or C-diff. Participants stated compliance to isolation precautions was limited because they frequently increased the residents’ behaviors.

It was real difficult, because you're trying to, especially the ones that will come out and wander and everything. You're trying to put on PPE real quick so you can go and take care of whatever it is they need, especially if they have C-diff and they like to run around and strip their clothes off and go in other people's rooms and you're like, no, please stay. That was tricky, but I mean, we would do it. (Participant 11)

Yet, during the COVID-19 pandemic, isolation precautions were used throughout the locked unit. Many participants stated these precautions still increased the residents' behaviors over time. Participants experienced a decrease in thoroughness in following the precautions.

Some participants noted that the increase in residents' behaviors correlated to reducing their social interactions with friends and family. This limited socialization seemed to increase depression in residents as well. "It definitely changed them when they couldn't see their families and then family, the window visits were the worst. They would be telling them to come in and they didn't understand it" (Participant 10). As participants experienced the increased use of isolation precautions, such as always keeping the residents in their room, they experienced increased job stress when providing care to more agitated residents.

I think it was frightening to a lot of those residents. They didn't understand trying to keep people in their rooms and away from each other. They're used to touching everything. It was very difficult. It was a lot harder to manage for sure. (Participation 4)

The increased depression participants saw among the residents also affected how participants felt towards the precautions they were asked to utilize or enforce. "I felt like we were all feeding off each other. Like if one of us had a depression moment, we all had that depression moment. If we, if we caught one crying, all of us was crying, even residents" (Participant 9). Participants then experienced a decrease in their compliance with PPE use, such as masks, face shields, gowns, and isolation precautions to improve the residents' quality of life.

I just pulled it down. I'm probably on camera pulling my mask down, taking my shield off. I'm probably all over that place. I mean, they can't hear you. They're already elderly. And then you have a mask and shield, you got two barriers that you are trying to talk to them. And I mean, in all honesty if my mask and my shield mask are what's causing you

to have behaviors and you'll stop, especially if I'm doing ADLs, and you have them in a room, I mean, you might as well take it off. (Participant 1)

PPE Usage

All the participants had extensive experience utilizing PPE and hand hygiene before the pandemic. However, most of their experiences were limited to the use of gloves and regular hand washing practices.

If they was in contact isolation and we would obviously have to use PPE actually on when you do care with them, you'd have to have your gloves on no matter what, so you always have some kind of PPE that you're using. (Participant 8)

In addition, all the participants stated they had minimal experience using face masks, face shields, or gowns before the COVID-19 pandemic.

Hand hygiene once every two seconds. Exactly. But PPE and all of that, I mean, if someone had like C-diff or MRSA or something like that once in a blue moon maybe like once every month or so. Not very often. (Participant 11)

Many of the participants also experienced increased behaviors during the pandemic using face masks, face shields, and gowns.

So, it's kinda frustrating, but sad because they don't understand why they have to stay in their room or why we have to be, have the yellow gowns on to take care of them. So, it was hard to get them to understand if they was even able to understand the reason why we all, that we had to put on all the gear that we put on just to come in and take care of them. (Participant 4)

A few participants stated they felt this rise in behaviors was due to the resident's fear of these items and not knowing what was going on or why they were being used. "I remember there was

one specific resident that if she saw anybody in a gown, I don't know why, but she just hated it. Like she freaked out” (Participant 7).

Lockdown Procedures

All participants stated they had little to no experience in lockdown procedures before the pandemic. Participant 7 said they had experienced a facility’s lockdown due to a Norovirus outbreak.

We did visitor restrictions when we had a Norovirus outbreak. So, we kind of learned.

We were kinda, we knew about window visits, we did a lot of window visits at that time.

But I still don't think that's comparable to what we had to go through. I wouldn't say that there was much true lockdown training. (Participant 7)

This lack of experience created a lot of confusion for the participants as these procedures began being used more regularly.

I remember prior to COVID going over drills, like what we would do in this or that situation, but as for lockdown for COVID-19 I don't think anybody was really prepared.

(Participant 3)

Quality of Care

Participants were asked about the quality of care they were able to provide throughout the pandemic. Adaptations for providing care were regularly needed, including increased use of bed baths, tearing towels to have washcloths, and RNs and LPNs providing more assistance to the CNAs. “Like the lack of the linen, the washcloths and everything, and us having to, cause sometimes if I didn't have a chance to make it down, we'd have to cut up towels and use towels as wash washcloths. That definitely made it harder” (Participant 6). Ensuring proper hygiene was a challenge. A decrease in the residents' hygiene was a common experience for the participants.

Many stated this was due to the inability to use the shared shower rooms for fear of spreading the virus. “I guess they had the military base come through and do the whole infection control thing. They thought if we took them into the shower room we were passing it to somebody else” (Participant 9). Some participants said they were happy to have more one-on-one time with the residents as isolation precautions limited the residents' ability to get out of their rooms and socialize with staff or each other. “A lot of them get a lot of one-on-one care from me than they would have before the pandemic” (Participant 5). Participants would often go into the rooms and visit residents during their downtime as the staff could no longer leave the locked unit, especially when it became a Red Zone.

I tried to in memory care, you get some time there where you're able to spend quality time one-on-one with a resident. It might even just be five minutes, but just giving them that one-on-one attention, I think made them feel better even just for a little while, but I don't know that was just one of my strategies. (Participant 3)

Outcomes of Policy Changes

When asked about the policy changes experienced in their facilities throughout the pandemic, many participants expressed feelings of frustration. Isolation policies, social distancing policies, PPE policy changes, red zone policies, and COVID testing and screening are all included in the policies discussed throughout the interviews. Often policies changed quickly with little to no explanation as to why. The unclear direction, and uncertainty experienced by many participants contributed to their feelings of frustration. Participants were asked what policies improved the quality of care provided, with most simply stating, “none.”

I don't think they got very good quality care during COVID. I can't think of a single instance. I mean, except for the staff that actually cared enough to play music when they

were dying and crack the window just a little bit right before they went and stuff like that. But no, nothing that improved their quality of care. They restricted their activities and, their families weren't allowed to see them. A lot of them, they had family that would come in every single day or once a week. And, they didn't get to see them for near a year. And, I think that's what part took some of those residents. So, I don't really have any pros, anything that we did that improved quality of life, which sounds really sad, but it's the reality of it. (Participant 11)

The outcomes of policy changes focus on the participants' experiences as the expectations and policies changed throughout the pandemic.

Isolation Policies

Participants reported an increase in the use of isolation precautions throughout the pandemic. Before the pandemic, participants experienced one or two residents at a time being asked to remain in their room. "Not that many times that I remember. I mean, it probably was for someone who was sick or something or they felt they had something and they put them on isolation. But not that many times that I can recall" (Participant 2). As the pandemic progressed, the participants were asked to keep the residents in their rooms. Some stated that window visits helped limit some of the impacts of isolation precautions, such as no outside visitors. However, the window visits also increased the depression of some residents.

They pretty much shut down visitation right off the bat and there was no visitation. We did do virtual visits and window visits that was the first thing. And, that was probably the most effective thing I think in limiting the flow of traffic in and out. (Participant 7)

In addition, participants stated that isolation precautions decreased the socialization of the residents by limiting the visitation of family members. "Everything stopped. They took away all

activities. When they started being able to do the window visits and everything, I guess that would kind of help some, others that would just kind of more hurt than anything” (Participant 6).

Social Distancing Policies

Social distancing was another difficult policy for the participants and residents to follow. The participants expressed frustration with maintaining six feet of distance between residents and isolating residents who wander to their rooms only.

They wanted, some of the first were, like socially distance tables, but once again, when you've got maybe three staff members on a unit of 25 behavioral patients you can only do so much. It's separating tables and try and keep everybody distanced and stuff.

(Participant 11)

Although some participants stated that social distancing helped limit the spread of the virus, many experienced difficulties enforcing this policy with residents. Some policies were used to improve the social distancing of the residents, such as providing meals in their rooms or separating them at different tables in the dining areas. However, these policies were complicated for some participants because the residents had a limited understanding of staying away from one another.

Definitely having to wear all of the PPE, I think was frightening to a lot of those residents. They didn't understand, you know, trying to keep people in their rooms and away from each other. They're used to touching everything. It was very difficult. It was a lot harder to manage for sure. (Participant 4)

A participant recalled having difficulty finding enough space to keep residents six feet away from each other in the dining room but needing to keep them out of their rooms as the residents were at risk of choking.

Participants were often encouraged to provide activities for the residents in their rooms, but at times were met with difficulty due to the inherent limited attention to the task that is a common symptom of dementia.

We would try to do more individual activities, you know, tried to talk to staff about what different approaches they could use and what they would normally use just to try to keep their residents calm and feel some sort of normalcy; you just kind of had to re-work a lot.

A lot of it was trial and error. (Participant 4)

Other participants utilized different activities to keep the residents distracted and help keep them in their rooms or away from other residents.

Watching TV, they all have TVs in their rooms, their own personal TV. Trying to keep them focused on the TV or get little fidgety things that they can play with, or they have baby dolls, that some of them play with. We have a couple of patients that like playing with puzzles. So we were just individually giving everybody something to do.

(Participant 5)

PPE Policy Changes

Participants also experienced increased PPE usage throughout the pandemic. This included increased use of masks, with requirements changing, including what masks to wear, when to wear them, and how often to change them.

They started to change from at first, we were able to wear cloth masks. So, everybody's wearing their own cloth masks. They provided, you know, the company logo, cloth masks and stuff. We could either leave them there or take home to launder them, or we could leave them there and they would launder them for us. But then it went to paper, well not paper, but surgical masks, and at first it was just regular surgical masks. We had

like a paper bag hung on the wall, with our name on it. And we could replace it. Well, first we could replace it every day, but then it went to every other day, and then once a week and then we were kind of grossed out at that point. We never had fit testing for N95s. (Participant 7)

Some participants also experienced a general shortage of other materials such as linens for beds or bathing.

Our laundry department got to the point where they felt like they needed to throw bed linens away and they were terrified. Then we ran on shortage of laundry being done because they would, if they weren't throwing it away, they were quitting because they were terrified of what they were coming in contact with. (Participant 9)

Many participants expressed frustrations with the increased use of masks for themselves and enforcing the use on residents. “At first in the beginning, they were kind of like, what is all this yellow stuff you guys. They were kind of scared at first with the shields and the masks, but they eventually got used to it” (Participant 5). Masks had to be worn all day, with many participants asked to re-use the same mask for days, sometimes weeks. Face shields and gowns had to be worn multiple times for all participants.

The masks, I would say, the masks were the only thing that we really struggled with having. They wanted us to reuse the same mask over and over again, and that became a problem. A lot of people was not liking that. I would say shields also. We sometimes ran shorter on shields. (Participant 9)

Many participants expressed frustrations with providing care for the patients when wearing the N-95 masks and face shields. “Some days it was like, oh, it's totally fine to reuse your N95 for

three months. Oh, now you need one to rotate every five days.” (Participant 11) All participants reported increased use of masks, face shields, and gowns increased the residents’ agitation.

I would say probably the masks and the shields changed the quality care. And, I only say that because there's a few of them that get really scared if you come in with those shields on. The don't want you to touch them. And then it's a whole new behavior and that behavior can last for a couple of days with some of them. So, you're going a couple of days with a resident who's missed a shower or missed multiple toilet things and stuff like that. And I feel like their care, I mean, because we have to wear that stuff. (Participant 9)

Participant six also experienced increased behaviors when providing care to residents while wearing gowns, masks, and face shields.

Sometimes the face shield, dealing with certain residents, the face shield was kind of not an option because it would either get ripped off my face or get smacked at or get hit. So, that was kind of definitely a hard one. Same with the gowns. Some of the residents, same resident in particular, didn't really like the gowns. So, she would kind of try to pull them off of us while we're trying to perform care on her. And then again, the masks, some of my residents I'll have to pull down my mask so that they can actually be able to hear me and understand what I'm saying. (Participant 6)

Many participants stated the masks limited their communication with residents. This often resulted in the participants pulling down their masks to make it easier for residents to understand or hear them, resulting in some participants decreasing their use of the masks altogether.

I have one resident in particular that always says, “Why are you mad at me?” Because that was just my eyes. So, I would, when I went in every morning, I'd pull it down and be

like, “Good morning.” And then I'd put it back up and try to make my eyes sparkly. It made her feel better when she could actually see me smile. (Participant 10)

A couple of participants had trouble enforcing the use of PPE with residents who have dementia, stating the residents would take the masks off. One participant recalled being asked to provide a mask to all residents on the memory care unit and feeling frustrated that these masks would be wasted as the residents were not likely to keep the masks on.

I feel like the masks and the face shields affected the quality of care because I think it scared a lot of them there. I mean, it was something new to them. Especially when they were hard of hearing, it's really hard to talk through all of that stuff. (Participant 3)

Red Zone Policies

All participants experienced some form of trying to separate the residents who had tested positive with the COVID-19 virus from those who had not. The designated area for positive patients was called the Red Zone, with all positive residents being moved to this area to decrease the spread of the virus.

Once COVID was out of our building they really did get a better grasp on what they were going to do. One of those empty units turned into when they finally did take admissions. One of them was the admit pod until they could get swabbed and then (stay there) two weeks and then staff was getting swabbed, three times a week. Then the other unit was just left empty in case we did get a positive case and then that person, and their roommate and, or anybody that came into contact with them would go to that unit. So, that was nice, but that wasn't possible in the very beginning. (Participant 11)

Participants frequently experienced difficulties with having enough staff for two separate areas.

Another nurse that was on the hall with us. She no longer works there and neither does the other aid now, she was my hall partner. We all three did it. It was such a struggle for her back there that I would have to bounce from where we had it split off. I'd have to bounce back there and help her, even though I'm supposed be on the yellow zone, I still was bouncing back and forth from yellow to red to help her. (Participant 9)

The barriers used to create separate locations were also challenging to keep in place, with some participants experiencing residents of their locked unit tearing down the barriers or pushing through.

The ones that were COVID positives that were able to get out of bed and be ambulatory. They would just push past that barrier and we're trying to keep them back there. The aids working with one, I'm doing med pass and then the aid for the "clean side" is what they called it. She's in a room doing something. So, like they're just out here and then we have to redirect them back behind the partition and it just, I mean, they were going to do what they were going to do anyway. (Participant 11)

The participants who did experience working on the Red Zone stated that it was very emotionally challenging to work on that unit. One participant recalls feeling isolated and alone as many of her residents began to pass away from the virus.

Working the red zone back there on memory care was really rough. Cause we lost a lot of them back there and just, you know, I spent as much time as I could, especially when they were actively going. And at that time, sometimes we didn't know if family were going to be able to come in to speak, to spend that time with them. So, I just, personally you don't want anyone to have to be that, to go through that alone. (Participant 3)

Another participant remembered experiencing feelings of depression with the residents she cared for as they lost friends to the disease.

I felt like we were all feeding off each other. Like if one of us had a depression moment, we all had that depression moment. If we caught one crying, all of us was crying, even residents. I felt like if somebody, one of them was having a bad day, we all felt that bad day. And then we all were having that bad day. So that change kind of set us all into a depression state back there. I think it mentally messed with all of us, residents included.

(Participant 9)

COVID Testing and Screening

COVID-19 testing and screening were two other standard policies utilized in facilities. Some participants stated that these policies helped decrease the positive cases in the buildings they worked.

Management Support

Participants were asked multiple questions focused on their experiences regarding the support provided by the management teams at their buildings. Participants who held some level of managerial role throughout the pandemic reported more positive management support than those who were not. This section focuses on communication between management and the staff members, provision of supplies, and staffing difficulties. This communication includes the changing policies discussed earlier and communicating with staff when emotional turmoil became challenging to cope with. The provision of supplies was also addressed, focusing on many participants discussing their experiences as supplies became less available. The staffing crisis that participants often experienced was addressed as well.

Communication

Communication was a common theme expressed by participants. Their experiences during the pandemic, specifically the limited communication between management and floor staff, was a common theme between participants. The constant changing of policies with few explanations for why the change was made frustrated participants.

It was scatterbrained at best, because like I said, their policies changed every five minutes and they were trying to compensate. Staffing was low. They were focused on getting staff in there, but nobody wants to work. Half the staff sick and half the staff doesn't want to work. And then it leaves the rest of us. So, they were existent but non-existent, they weren't on the floor with us. (Participant 11)

Participants found that when multiple changes were enacted quickly, there was confusion regarding what policy would be followed.

Well, everything just changed so quickly, it was hard to keep up with all the changes.

One day we could have a policy and it would change that same day. It was just hard to keep up with all the policy changes. (Participant 8)

Some participants, however, did state that the communication around COVID-19 was sufficient, and these were primarily those in managerial roles.

It was a little more difficult than I anticipated, mainly because everything changed almost on a daily basis. And sometimes, honestly, several times a day. So, I think we were as prepared and communicated what we knew as we knew it. (Participant 4)

Those in managerial roles stated they would often try to provide as much education as possible to their floor staff.

Oh, on my unit we had continuing education, education, education. Like, how to wash your hands, make sure you're wearing the proper PPE. I would go around and check, and ask questions, see if the staff had any questions, that I was continuing with me and keeping in contact with your staff. Seeing how they're coping with the situation that was at hand. You know, they all, we all, went through it. It was a lot to go through. You know we lost our grandmas and grandpas that were fine one day, and the next day they were gone. Just making sure they were coping ok with it. (Participant 8)

Those in managerial roles such as unit managers or directors of nursing would often express similar frustrations with the changing policies. However, they would also say that they felt they did their best with what they were provided at the time.

It was a frustrating time to be in the position I was in because I was on the floor. Like I said, just as much, if not more than I was actually on a management level. I felt the brunt of not having the same things I needed to do, what I was told to do. But I also had to say, "Well, we have to do it this way because that's how we have to do it." And I felt, I've always felt like I was kind of a double agent because I have to enforce these things. This is my job. Whether I believe in it or believe in the ethicacy (ethics) [*sic*] or value of what I'm told to do, but at the same time, actually doing it the way they're telling me to, and it's not realistic. I kinda had that professionally. I had to stop myself from griping with the other nurses. Cause you know, I couldn't cause I'm one of them in a way. I mean not corporate, but I'm one of the enforcers. I'm management. I couldn't be like, "Yeah, I hate this" like, I just had to be like, "Well this is what we're doing today guys, so do it." (Participant 7)

Provision of Supplies

Provision of supplies was another common theme expressed by participants as key in their experience of COVID-19 in their facilities. Participants experienced shortages in masks, gowns, soap, hand sanitizer, cleaning materials, and linens. Some of the participants experienced having to get supplies outside of their facilities, with some stating they would buy items on their own.

All right. Well, to be honest, if we were short washcloths or towels really, I'd probably go down to the Dollar General right down the road and buy some myself and use those.

Blankets or if we were short on fitted sheets or anything. Sometimes I can just use the flat sheet as the fitted sheet. When it came to certain products or shampoo products and everything like that. If we'd ever run out of that, I would go down and provide that. I just kinda made whatever I could work. (Participant 6)

All the participants said they experienced a need to adapt their supplies or how they got their supplies to accommodate the needs of the residents. These adaptations included tearing towels to make washcloths, using flat sheets for bottom sheets, making hand sanitizer with rubbing alcohol, making cloth masks at home, or tying towels around their face as a make-shift mask.

Once things started getting to a point of, like you're on complete lock-down, and there's a red zone, I guess it was more of strategizing how to make the most of the supplies you have. Make sure you have everything back there first off before you can even go on.

Cause I don't know how many times I walked into day shift, and I didn't even have the supplies I needed to do my job nor did the aides have the supplies they needed to do their job. (Participant 1)

Some participants said they never experienced a shortage in PPE, stating they could often find what they needed with the help of others.

There's times that I honestly went without a shield. There was a couple of times that, a nurse and another aid that was my hall partner back on our unit we actually used a towel at one point. We were tying towels around each other's faces just to get in and out of the rooms. And we would text management. We'd let them know, "Hey, this is what we're having to do" with no response whatsoever. (Participant 9)

Staff

Limited staffing was also a common experience among participants. Some participants stated that teamwork and consistent staff helped alleviate the limitations in staff. When asked if there was anything that helped when there was limited staff, one participant said, "No, not really, long hours, a lot of hours" (Participant 8).

Participants also expressed frustration in feeling supported throughout the pandemic. Many participants felt the locked unit was isolated and frequently forgotten by management.

I just feel like the people from the regular side of our building, rather than the unit, they really didn't support us. I'll probably have to call and ask for gloves or something. I feel like they really didn't support the unit because we was locked up. Well, we was locked away. (Participant 2)

The participants also repeatedly stated that they felt misunderstood by management when policies were difficult to adhere to due to working with this population.

I just felt like as far as policy changes every single day they were telling us to do something different. That was kind of frustrating cause we didn't have the resources that we needed and they just they're like, "Okay, here's a flyer with the new policy, do it, do it

now.” And they were not lenient on, okay, well we don't have the staff or we don't have this resource or that they were just like, “We don't care.” I didn't ever say we don't care, but that's the way we felt. It was like, they didn't care how we had to get it done. We just had to do it. And it wasn't realistic on our level. We felt like people that were implementing the rules, never even stepped foot inside of a facility. They kind of felt that way. It was just a very high stress, intense time. Everybody was negative. We just felt like we were kind of just out there and getting guidance, but no help following through with what the guidance said to do. (Participant 7)

Participants also expressed frustration when asking for assistance from management when needing supplies that were essential for the care of their patients.

People bringing us stuff. I feel like, I mean had a whole situation. Someone needed the oxygen concentrator cause their O2 was dropping and it took three hours to get. I was leaving when they finally brought my oxygen concentrator and I called them hours before. (Participant 1)

Suggestions for Future Pandemic

The participants had many suggestions to improve the response of facilities to the next potential pandemic. One recommendation to improve care in a future pandemic was to decrease PPE use for residents.

I guess they did change something with the mask. We had care plans put in their files that stated that they didn't understand the mask. I forget how social services worded it, but that policy I guess, came in and that was smart because they didn't understand it. It kind of saved us a little bit with trying to deal with the headache of keeping a mask near them and all that. (Participant 1)

One participant had an experience where staff wore masks with “windows” to see their mouths when they spoke.

At one point, our new physical therapy director, she got us masks that they could see our mouth and immediately everybody lost their minds. “No, those aren't effective.” I'm like, “What do you mean they're not effective? They can see our mouths.” And they were like, “No, they're not approved by the state or you have to wear these.” (Participant 10)

Many participants stated this was often the cause of agitation with residents.

Some suggested focusing on the mental health of the residents as much as they did their physical health. Many participants stated their primary focus would be to change as little about the resident's daily routine as possible. “I'm just really big on the whole change as little as possible back there because it's just setting us up for failure. Honestly, that's how I felt the whole time” (Participant 7). These suggestions at times were vague, with a clear understanding that this is difficult when trying to keep them safe and healthy.

I think you have to say, “Okay, well, you know what, we still have to go on with everyday life.” So how do you implement the things that you're supposed to be doing from a safety standpoint not effecting their daily routines and their familiarities with the way their routines? I mean, you, I think if you could figure out a better way to not change things so much for them, you know what I mean? (Participant 4)

Many participants experienced increased anxiety and depression among their residents, stating that the sheer boredom of the residents likely contributed to their overall decline.

They needed something to do that entire time. It weighed heavily on them, the activities thing, because they took out all of our, like anything that we had on the unit that they, that the residents could touch. It was gone. So, magazines, puzzles, they had some that

had these little blocks that they would stack and play with. I think that sheer boredom that contributed to some of them not having the best outcomes either. They couldn't see their families. There's nothing to do. The staff is stressed about these people that they've known for years. They're all stressed out, running around, but they have nothing to do. They just kind of sit there. So, I think that was, it's a nonclinical stance, but I think it's clinical at the same time. (Participant 11)

Another suggestion was to increase the outdoor time allowed to residents.

Well, with the lockdown unit for memory care, like I've said, they have a courtyard. Through the whole pandemic, even in, when it was a nice day outside we weren't able to allow them to go outside. I don't know the reasoning behind all that, but through the whole pandemic, I heard that it's more outside. You were less at risk than you were inside. So maybe taking a couple, so you can still social distance to get some fresh air, to give them a different scenery instead of being in a locked unit the whole time. (Participant 3)

These experiences led participants to express concerns for their resident's overall well-being when they were forced to stay locked up and isolated from friends and loved ones.

Participants suggested throughout the interviews increased support from management. Their desire for increased face-to-face interactions with the staff providing care to the residents would help reduce feelings of being ignored or forgotten. "Check on us. Just check on us, ask us if we're okay. Come back to the doors of the partition, say 'Hello, do you need anything?'" (Participant 1). Participants often expressed frustration with management or corporate limiting their time helping the staff who were working directly with the patients.

To remember that we have families too. That we give a lot of our time as well away to come in and care for residents. And I feel like they should do the same. I don't feel like they should be secluded to their offices and not helping; they should be on the floor with us. (Participant 9)

One participant recalled an event in which she had an encounter with someone from their corporate building. She was frustrated with the corporate representative focusing more on the participant's lack of compliance with PPE at that time, than on the psychosocial need of that participant in a moment of fear and frustration:

There was one guy that I was back there feeding him. And, he hadn't eaten in like three days and he sat up, he was one of the facility favorites. He had nobody the state kind of just dropped him off on us and he didn't have anything. He didn't have any family. So, we all kind of went into him. Well, he asked for something to eat. So, I sat down with his little, pureed tray, but the pureed food wasn't, I guess, fully pureed, if that makes any sense. It was kind of bumpy at the one spot. So, he ended up choking and I yanked him out of that bed and was beating on his back, trying to get him to cough it up, cause it was, it was pureed food. And I yelled for the aide, they had to run across the building because the crash cart was on another unit and I was going for a suction machine to clean him out. And when I went running down, the hall corporate was in the building and they watch me, full PPE, N95 and everything went running back with like five or six nurses, just saw me like running down the hall. So, they (the other nurses) took over for me and I was standing in the common area. Everybody's in the beds, dying at this point. No one's up moving at this point. And I had my mask down over my chin, cause I'm hyperventilating. I'm like, I nearly killed this man because I tried to feed him and he should not have been

eating, but you know, he wanted to eat. And here comes corporate. They're like, "Where is your mask?" And I'm crying hyperventilating in the middle of the pod. And I'm yelling at her, "Its around my 'fing' neck." It was awful. I was like, "Get some compassion lady. Like we're going through some stuff right now, okay." (Participant 11)

Another suggestion was to improve the communication of policy changes, including explaining why some policies were created.

I feel like being upfront and honest, not having the fear of, putting fear into people, but you know, just not that don't get me wrong. I'm not saying anybody we was dishonest about anything, but I think just more of a, "Hey, you know what, we're not really sure. We're not really sure, but this is, this is why we're doing this, and this is why we're doing it." Kind of thing. (Participant 4)

Caregivers that are the same for each shift, specifically for the locked unit was suggested by multiple participants.

I would definitely say that they need to stick with a set staff in the unit. So that way you're not, I guess having aids and nurses come from like center or your rehab hall back to the unit, your yellow, not bouncing people around, I guess, during it. That would definitely help that. (Participant 6)

Increased staffing was also suggested by multiple participants as well.

I think that we definitely could have used more staff. I think that's probably everybody's answer. When you have a limited number of people and you're trying to incorporate their [the residents'] psychosocial wellbeing, which I think was huge. I think that we saw a lot of people decline mainly because of not necessarily physical, but because of the psychosocial aspect of everything. Maybe if we have more staff, more availability to

spend more quality time, instead of. Which in general, I feel like on a memory care locked unit, you kind of have to change your mindset of, you're not just here to provide physical patient care. I think on a memory care unit it's psychosocial all the time. I think maybe having more staff, obviously if we had more space, maybe even, using an additional area in the building that could be locked to try to spread people out a little. I dunno [*sic*], that's kind of a hard one too, but I think definitely more hands-on that kind of could have been useful. (Participant 4)

Some participants also suggested providing mental health support for staff from the management team specifically.

There's just so many things that we got hit. I had I think he was four or five months old at the time. My son was not very old at all. And, being hit with our first case and all that. But some of that stuff is blocked out with just the sheer amount of death. Every single day. So, all of us need therapy after, you know, what happened at those buildings like that? I don't know if it's like that across the board as bad as what our's [*sic*] got hit. I'm sure it is. But it was just a really, really bad situation. I hope we never have to go through again. (Participant 11)

This could include counseling offered to staff members or for management to give face-to-face support to staff when they have lost a resident.

Most participants also suggested increased training for the next potential pandemic, with some participants suggesting training for adaptations for providing care.

I think that like how you have fire drills, tornado drills. I think we should have a pandemic drill. I think that if the residents got used to hearing and seeing that they would not be so freaked out so much. I know it does freak them out and they can't help it, but I

feel like if it happened on a scheduled basis, like with the fire drills are, I think they would be more accepting to it, maybe. (Participant 9)

Another common suggestion was for increased dementia care-focused training.

I would say make sure they have a dementia training class, like a basic, beginning dementia training class, so they even understand dementia. And then on top of that, I think, try to come up with some type of class or training with dementia from people who have dealt with the pandemic. And, maybe if they can't come up with a class then figure it out from people who have experienced it in dealing with dementia, cause it's really hard trying to be a nurse, an aid, a dietary, housekeeping and try to keep your residents engaged. (Participant 1)

Some participants also suggested increased training for PPE use, including how to don and doff appropriately. "I would say just the proper equipment, knowing what proper equipment you're suppose to use and how to you're supposed to use it. I think those would be important, hand-washing, hand sanitizing." (Participant 8)

Discussion

This study focused on the experiences of skilled nursing staff who worked with PWD on a locked memory care unit during the COVID-19 pandemic. As this pandemic has continued to evolve and affect daily lives throughout the world, the individuals of this study have continued providing care to a very vulnerable population while adapting to how healthcare workers are expected to do their jobs.

Reasons for Working on a Locked Memory Care Unit

All the participants expressed an overall feeling of love or passion for working with PWD. Their love and compassion for this population have served them well over the years and

are likely what has driven them to continue working with PWD through these extraordinary circumstances. This compassion and drive to provide a quality level of care to their patients who also require extensive assistance in all aspects of life likely caused what Steinheiser (2018) refers to as compassion fatigue. Recognizing the level of care these staff members provide to this population should be recognized by those who supervise them. Providing nursing staff members with recognition regarding their closeness and relationship with their patients increased their feelings of job satisfaction (Anderson et al., 2010).

Experiences Working with People Who Have BPSD

The participants often expressed frustration or felt overwhelmed when working with people who have BPSD. Woodhead et al. (2016) had similar findings suggesting that feelings of depersonalization, emotional exhaustion, and decreased personal accomplishment increased the risk of burnout among nursing staff in long-term care facilities. As participants in this study appeared to confirm these findings, the feelings seemed to increase further as the stressors of the pandemic increased. However, many studies have provided recommendations to decrease these feelings. These suggestions include increased supervisor social support (Woodhead et al., 2016), better training and support from supervisors (Islam et al., 2017) and promoting self-efficacy of staff who provide care to PWD (Coates et al., 2019). In the case of an emergency such as this one, it appears these recommendations were not utilized to their fullest potential. Islam and associates (2017) highlighted the importance of addressing the stress and burnout among nursing staff in long-term care facilities, especially those experiencing a crisis. Keeping in mind the psychosocial needs of nursing staff, especially in an emergency such as this one, could help provide better support for nursing staff members who care for such a stressful population.

Training

This study asked participants how they perceived the training they had before the pandemic and how it prepared them for the realities they faced. Many studies have shown that nurses and nursing assistants felt their training did not prepare them for the realities of a pandemic (Aiello et al., 2011; Fernandes et al., 2021; King et al., 2021). Overall, participants expressed frustration over the lack of preparation for the realities of a lockdown such as the one they experienced during this pandemic. Fernandes and associates (2021) also found that nurses have not been provided much education focused on pandemic preparedness. Many participants' training before the COVID-19 pandemic focused only on short-term lockdown procedures such as those used for a weather emergency or active shooter. Aiello and associates (2011) also found that nurses were not prepared enough for the realities of a SARS or H1N1 pandemic. Lockdown procedures that participants named during the pandemic included eliminating outside visitors and only in-house staff were allowed in or out of the building for months at a time. Participants suggested further training focused on the realities of quarantine or lockdown may improve the response from residents. This training could include "drills," assessing the knowledge and preparedness of a facility and its staff for similar lockdown procedures. Education could also include appropriate adaptive techniques for providing care to PWD to decrease the risk of BPSD when they need to remain isolated or quarantined from others.

Staff working in long-term care are often trained in the prognosis and progression of dementia and appropriate techniques for providing care (Ehlman et al., 2018; Takizawa et al., 2017). Participants in this study often referred to orientation or in-service training used for educating them on aspects of dementia care. However, none of the participants stated they required specialized training beyond the simple in-service training to work on the locked

memory care unit. However, many participants did state they had sought out more specialized training on their own, or would participate in further training if it was offered or paid for by the company they work for. Islam and associates (2017) suggested that improvements in training nursing staff in dementia care can improve the quality of care provided. Many participants of this study said they volunteered to take more in-depth training courses if their employers offered them. Those participants who had an opportunity for more extensive training in dementia care often stated they felt capable of providing care to complex patients who may have more aggressive behaviors. The strategies taught in these specialized training courses often offered a better understanding of people living with BPSD and methods for providing care to these individuals (Ehlman et al., 2018). Providing more in-depth and specialized training for staff who work on locked memory care units could improve job satisfaction in nursing staff and decrease the BPSD experienced by PWD in these units.

Participants often stated they were comfortable using gloves and handwashing or hand sanitizer before the pandemic. This was typical training for participants when training for their credentials and often as in-service training within their facilities. Most participants were also familiar with the use of gowns and masks when providing care to individuals who may have had a significantly contagious infection. However, the extensive use of gowns, masks, and face shields was unfamiliar for participants before the pandemic. Though they were trained on the use of these PPE, they were not trained on how to react to PWD having behaviors regarding the PPE. The more extensive PPE items (e.g., N95 masks, face shields, and gowns) increased the participants' feelings of stress and frustration. They often reported frustration in communicating with their hard-of-hearing patients. Some participants also stated that using face shields, masks, and gowns would increase the fear and anxiety of some of their patients. Agitation, aggression,

and anxiety are common behaviors experienced with individuals who have moderate to severe dementia (Arai et al., 2017). Participants experienced some patients becoming more aggressive when wearing masks and face shields. Providing better education for staff members on how to calm PWD when they are experiencing BPSD in relation to PPE is important. This training could help further improve participants' feelings of preparedness for future pandemics.

Policy Changes

As the novel coronavirus (COVID-19) has continued to ravage the world, it has also brought many new changes and recommendations. As these changes have evolved, so has the approach nursing staff have been asked to use while treating their patients. However, some policies or recommendations from the CDC have remained the same. Social distancing and quarantining continue to significantly strain people with dementia and those who care for them (Cohen et al., 2020).

Participants often reported difficulties providing care for PWD when they had to quarantine them in their rooms. Wandering is a common behavior experienced by PWD and causes a significant need for caregiver supervision (Agrawal et al., 2021). Wandering was a common behavior that participants experienced having difficulty with when required to keep a PWD quarantined or isolated in their room. Social distancing was also difficult for participants to enforce with PWD, specifically those who would wander or demonstrate limited acceptable social standards such as eating food off another individual's plate. These behaviors were experienced at a heightened level of intensity when the patient would test positive for COVID-19 and must be moved to a "Red Zone." Arai et al. (2017) found that PWD who isolated themselves from others demonstrated an increase in BPSD. Recognizing the socialization needs of these individuals is key in providing an appropriate level of care. Finding ways to provide socialization

to PWD when they have to be isolated from others will help decrease the risk of BPSD, and improve nursing staff's experiences providing care to this population. This could include a staff member who is responsible for staying with the patient during the day to eliminate the feelings of loneliness. It could also include providing these patients with individual activities that they enjoy.

The participants expressed concern regarding the loss of socialization for the residents with their families and friends from outside of the facility. Some stated that although window visits could help some residents feel less lonely, it would create more concerns for behaviors in other residents. Participants noted that it began to feel as if some residents' health declined due to this lack of interaction with their families. This loneliness was also experienced in a study by Trabucci and De Leo (2020).

A red zone was the typical reference to a COVID-19 positive ward, often a section of the locked memory care unit separated from the rest by a temporary barrier. Many participants experienced residents becoming agitated with the barriers and tearing them down or pushing through them. This would essentially make the barriers ineffective, increasing the risk of further infection throughout the locked units. Finding alternatives to keeping positive patients safely quarantined from non-infected patients would help eliminate the need for such barriers.

Socialization with peers and family and a structured schedule has been a standard of care for PWD for quite some time (Cohen et al., 2020). This was severely disrupted for many of the participants as they were asked always to keep their residents six feet apart or kept in their rooms. Some approaches utilized to adhere to this recommendation from the CDC and policy change from the companies they work with were to have the residents eat their meals in their rooms or in the hallway using a bedside table. The participants also expressed frustration when

having to keep residents who are at risk of aspirating on their food in their rooms, or those who needed help feeding themselves as this would then increase the time it took to assist all the patients with their needs and keep them safe. The prevalence of dysphagia in older patients with dementia is rising, increasing the risk of patients aspirating on food if left without supervision while eating (Espinosa-Val et al., 2020). Activities were canceled completely, with all participants reporting being asked to provide individual activities to residents to help keep them occupied while also providing assistance for ADLs and keeping their unit clean. This began to increase the feelings of being overstretched among staff members. These compounding expectations increased the burnout and stress of the participants. This was a common experience in other studies focusing on stress and burnout among staff members in long-term care, or while providing care to PWD (Cohen et al., 2020; Trabucci & DeLeo, 2020; Greenburg et al., 2020).

Support

Participants were asked about their perceptions of the support provided to them throughout their experience. Many stated a generalized feeling of frustration regarding the support they were provided from their buildings' administrators, directors of nursing, and the corporate personnel of the company for whom they work. Participants worked in multiple states and for multiple corporate companies throughout the United States. These feelings of frustration were often a result of feeling overwhelmed with the expectations of providing care to a very difficult population during a very difficult time. The lack of support from management and a shortage in nursing staff have both been linked to increased feelings of stress and burnout among nursing staff in previous studies (Stenheiser, 2018; Halifax, 2013; Islam et al., 2017; Tilden et al., 2012). Tilden et al. (2012) found that facilities with higher administrator turnover had a decreased reported quality of care from family members. Stenhieser (2018) found that limited

staffing and limited support from management increased the reported stress of nursing staff in long-term care facilities. Participants often reported lofty expectations from corporate management or building administrators as a consistent contributor to their feelings of stress and burnout.

Providing care to moderate to severe dementia patients is a challenging task (Hughes, 2001). The participants of this study experienced a significant increase in the difficulty of providing care for these individuals, with a lack of supplies and support. Staffing for long-term care facilities has often been an issue (Costello et al., 2018). Many participants stated that some staff members would get sick with COVID and must miss work, while others left due to fear of contracting the virus themselves. It should be noted this study focused on the timeframe between January 2020 and December 2020, which was before the COVID-19 vaccines were readily available to staff in skilled nursing facilities.

A few participants experienced some level of increased assistance or support from management. Those who experienced their director of nursing or building administrator providing social support or help to provide direct care to patients expressed less frustration. Anderson et al. (2010) also noted that supervisor support decreased the emotional exhaustion reported by nursing staff. Participants also expressed a desire for counseling or more emotional support from supervisors and administrators after experiencing the extreme loss of life due to the COVID-19 virus. Anderson and Ewen (2011) found that nursing staff in long-term care facilities expressed increased job satisfaction when provided counseling or other levels of support from management. These findings combined with the participants' experiences in this study suggest that the provision of social support from supervisors is critical in decreasing burnout and stress in

nursing staff. It would be especially important when staff is feeling particularly overwhelmed in times such as these.

Suggestions for the Future

Participants were asked what they would recommend to better prepare for an emergency such as a pandemic. Many stated they would recommend further training focused specifically on providing care to people with dementia. Although the participants were provided training as a standard yearly in-service training, these are often provided via an online PowerPoint-like format. The participants who expressed they felt comfortable providing care to PWD had received specialized in-person training lasting more than one hour. Ehlman et al. (2018) found that nursing staff who were provided a two-day specialized dementia training demonstrated improved understanding of their patients who experience BPSD. Implications for future training should focus on similar levels of training for nursing staff working on locked memory care units. This training could also better inform the nursing staff of appropriate activities or techniques for avoiding or decreasing BPSD. This knowledge could improve the overall well-being of the PWD and the nursing staff who care for them.

The participants suggested many things; one suggestion included the allowances for PWD, who live on a locked memory care unit, to roam freely within their unit. Many of the participants expressed a significant increase in BPSD when attempting to keep their residents isolated in their rooms or separated from their peers. It is common for nursing staff members to experience an increase in stress and burnout when their residents who have dementia exhibit an increase in behaviors such as anxiety and delusions (Liu et al., 2020). Providing care to PWD that focuses on what skills the person still has, and not forcing the PWD to conform to your needs or expectations can decrease the risk of such behaviors (Ehlman et al., 2018).

Consistent caregivers were also a common suggestion among participants, as this ensures that people who know the resident can provide better care. The relationship between the staff and their residents is an important factor in decreasing the risk of BPSD (Arai et al., 2017).

Improving the consistency of who is providing care to PWD on a locked unit can help improve the overall quality of care provided, as well as job satisfaction among nursing staff.

Limitations

This study had limitations that should be noted. The primary limitation involves the experiences of the primary researcher. They are an occupational therapist who worked in the same building as many of the participants and worked closely with many of the residents referenced throughout many of the interviews. To decrease this influence, the primary researcher utilized social media and recruited participants outside of the state and company that the primary researcher works for. The experiences from these other interviews helped confirm the similarities in experiences for all participants. The primary researcher also utilized a field journal to help identify when the primary researcher's own experiences of providing care to PWD on a locked memory care unit may have influenced their interpretation of the interviews.

The study would have benefited from more member checking participation. This would have enhanced the confirmation of results and decreased the risk that data was misrepresented or interpreted by the primary researcher.

The study timeline is another limitation of this study. With the rapidly changing policies and recommendations from the CDC and the provision of vaccines, the participants' experiences could have been influenced. Many of the initial interviews were completed months after the timeline in question. The participants' experiences could have affected their recall of events or their feelings about certain aspects.

Future Implications for Research and Practice

This study should serve as a guide to help policymakers better understand the realities of providing care to PWD and what to expect of the staff members providing care to these individuals during a pandemic or similar emergency. The suggestions made by these individuals help provide an awareness of the need for support from all levels.

Many of the participants identified an overall feeling of being forgotten by the managers and administrators of their building. Further research should focus on the benefits of managerial staff providing social support to nursing staff in long-term care. Identifying types of aid could benefit administrative staff to know what methods are desired from their nursing staff. It is common for nursing staff to experience increased compassion fatigue and stress when they feel less supported by management. It should be noted that although this study focused on the experiences of nursing staff, the criticism of management or corporate level managerial staff was common. Allowing individuals who hold an administrator or management position to provide insight into their experience may help improve the awareness and understanding of this phenomenon. Managerial staff experiences were likely different from what was expressed in this study.

This study sought to understand better the lived experiences of nursing staff working with a very vulnerable and challenging population during an extraordinary time in history. Understanding their experiences and listening to their suggestions for the future can help policymakers and nursing home administrators better prepare for the future in caring for PWD. One suggestion was made to decrease the restrictions placed on PWD, including social distancing, isolation, or quarantine. Further research on how to provide care for PWD while adhering to such limitations is needed to understand better how to provide a quality of life for

PWD while keeping others safe and healthy. It would then be suggested that instead of completely disrupting the lives of PWD to conform to limitations such as social distancing or quarantine procedures, adjust how care is provided to these individuals. The nature of a locked memory care unit is that it is isolated from the rest of the facility. Keeping the staff consistent, decreasing the potential for staff members or visitors to potentially bring the virus onto the unit, and keeping the residents safe within the unit while providing a consistent level of care and activities would help decrease the risk of increasing BPSD for this population.

Another common suggestion was focused on better training for future staff members. The training ranged from better training on how to care for PWD to what to expect during a pandemic such as the one we are experiencing. It has been shown that improving nursing staff members with better dementia training can enhance the quality of care provided (Ehlman et al., 2018). It is unlikely that anyone beginning a career in nursing is entirely unaware of some of the limitations faced when caring for PWD within this pandemic's realities. However, it is one thing to know things are different and another to understand how things have changed. Nursing staff members have had to learn a lot of different strategies to help keep themselves and their residents safe and happy during the past two years. Allowing these staff members to assist in new staff members' training or orientation process could help spread their knowledge and experiences.

When conducting research focused on nursing staff experiences, future researchers should also note that their time is often limited, and recruitment strategies should be expansive with multiple methods used. The studies that involve the experiences of CNAs, QMAs, and LPNs are limited. However, their experiences can help us to understand better how to provide the support they need to be successful when providing care to a vulnerable population such as PWD.

Conclusion

This study sought to understand better the experiences of skilled nursing staff who worked full or part-time on a locked memory care unit during the COVID-19 pandemic. Eleven participants were asked to shed light on the realities they have lived through providing care to PWD during a time when all the rules we know for giving care to this population had to be abandoned.

Participants experienced significant levels of stress, frustration, and feelings of having little support from management as they provided care to residents during the COVID-19 pandemic. The participants all expressed a particular love for the residents they care for. The participants' experiences caring for this population during this extraordinary time were often influenced by fear and the unknown, lacking prior training or experience. Further training is needed focusing on delivering care to PWD who experience BPSD. Many participants stated that more face-to-face interactions from administrators or supervisors would have been beneficial in feeling improved job satisfaction. Counseling was also recommended when dealing with the grief of losing multiple patients quickly due to the COVID-19 virus. These individuals worked tirelessly to provide the best care possible with limited support and a lack of needed supplies. They experienced significant changes in their residents, including increased behaviors and the loss of many of the residents they loved.

Nevertheless, participants showed resilience amid the challenges they faced and provided realistic suggestions for better preparing staff for future pandemics. As this pandemic continues, the recommendations made by these individuals should be considered. Adaptations should be made to how new staff is trained and how management can better support staff who care for a challenging population while implementing new and complex policies.

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Table 1*Theme Summary Table*

| Themes | Sub-themes | Quotes |
|---|--|--|
| Reasons for working on locked memory care unit | Love the residents | I have a love for dementia and feel that they should receive the same exact care that those outside the locked unit receive. (Participant 1) |
| | Unique population | I just like working with the different personalities day-to-day because you never know what you're going to get sometimes. (Participant 2) |
| | Family members had dementia | My grandmother and my grandfather passed away of dementia and I have helped them help my aunt and uncles and my mother, um, care for them. And I've just been interested in it ever since. (Participant 9) |
| Experiences working with people who have behaviors | Difficult to work with residents who have dementia | I've had them violently, fighting, hitting me, verbally abusing me. (Participant 5) |
| | Emotionally draining working on locked unit | It can be very frustrating. It's, I mean, it is a lot like dealing with children and, people, I think find it really hard to understand that your mind kind of goes backwards when you have dementia. (Participant 4) |
| | COVID symptoms changed behaviors | Especially the residents that actually did have COVID. They were really agitated about a lot of stuff. Compared to the residents that were in the yellow zone. (Participant 5) |
| | Difficult for residents to understand what was happening | So, it was tough times with their behaviors and trying to keep them, to be able to understand enough, to let them understand that they you know this was actually, we need to have you stay in your room can't come out or anything. (Participant 8) |

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|---------------------------------------|--|--|
| | Knowing the individual residents helped decrease behaviors | You kind of just have to learn what will trigger that aggression, or why they're being triggered, and learn how to maneuver around that aggression so that you can still do your job in an effective way. (Participant 1) |
| Training | No special training to work on locked unit | I just train normally like a CNA. Nobody really taught us how to take on the residents. (Participant 2) |
| | Elective dementia training completed by many participants | I've done the Teepa Snow training, I believe it was I think, eight to 10 hours and then, the dementia certification was 40 hours. (Participant 3) |
| | Hand hygiene, isolation precautions and PPE procedures included in credential training | We learned that in nursing school. (Participant 1) |
| | Lockdown procedures training limited or not provided at all prior to pandemic | Not prepared at all? This was actually the first time in my whole career that I've had to deal with any kind of precautions that we've had to deal with, with COVID. (Participant 8) |
| Outcomes of shared experiences | Isolation precautions rarely used before COVID-19 | Not that many times that I remember. I mean, it probably was for someone who was sick or something or they felt they had something, and they put them on isolation. But not that many times that I can recall. (Participant 2) |
| | During pandemic isolation precautions used more frequently | So, before the pandemic you're not faced with as much isolation precautions, on the memory care unit, or any unit, compared to what we had to do for COVID. (Participant 8) |
| | Increased isolation precautions= increased behaviors from residents= increased work stress | I felt like we were all feeding off each other. Like if one of us had a depression moment, we all had that depression moment... Like I think it mentally messed with all |

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|-----------------------------------|--|--|
| | | of us, residents included. (Participant 9) |
| | PPE usage increased throughout pandemic | I mean, all this stuff that we had to wear to go into the rooms was straining enough to us. (Participant 9) |
| | The use of masks, face shields and gowns increased behaviors in residents | Like with us having to wear the face shield, it definitely would start to make them more aggressive. I have a resident who, when, when you go in there with a face shield, she just turns and tries to rip it off. (Participant 8) |
| | Lockdown procedures used very little prior to pandemic | That actually surprisingly until probably the last four years was not ever a huge topic. (Participant 4) |
| Outcomes of Policy Changes | Many participants stated that there were no policies that improved the quality of care provided to residents | Nothing. Nothing. We just hung in there. (Participant 7) |
| | Isolation precautions increased depression and agitation of residents | It definitely changed them when they couldn't see their families, the window visits were the worst. (Participant 11) |
| | Masks and face shields limited the communication between staff and residents | It was just hard. I mean, I think (the PPE) scared them more than anything. (Participant 9) |
| | Mask requirements changed frequently, increasing frustration among staff members | It was, uh, it was a little more difficult than I anticipated, mainly because everything changed almost on a daily basis, and sometimes, honestly, several times a day. (Participant 4) |
| | Masks were worn multiple days/weeks at a time due to shortages | Well, first we could replace it every day, but then it went to every other day, and then once a week and then we were kind of grossed out at that point. (Participant 7) |

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|---------------------------|---|---|
| | Quality of care was difficult to provide with shortages in linens, soaps, and staff were common | To be honest, if we were short washcloths or towels really, I'd probably go down to the Dollar General right down the road and buy some myself and use those. (Participant 6) |
| | Some people enjoyed the increased one-on-one time with residents that resulted in the inability for staff to leave the unit when it became a Red Zone | I was able to spend more one-on-one time individually because they couldn't do groups and just sit with them. (Participant 10) |
| | Red Zone barriers were difficult to keep in place as residents often tried to tear it down or push past it | They would just push past that barrier and we're trying to keep them back there. (Participant 11) |
| | Social distancing was very difficult for staff to enforce with patients who have dementia | Yeah, just the isolation, social distancing, mask usage. It's like, uh, that that's not gonna happen. I have a mask on someone, but most of the time they're not going to respect the six-foot bubble at all. We didn't have the staff to feed everybody individually and we were supposed to not do community dining, but the best we could do was keep one resident at the table and then they use those little bedside tables to keep everyone spread out. (Participant 7) |
| | COVID testing and screening standard policies utilized throughout all facilities | I definitely feel like the testing help. I will admit I absolutely hate the testing, but I will say clearly it does work. And the check-in, or if you're not feeling good and then sending you home or quarantining you till, your test came back, I definitely feel like that kinda impacted positively. (Participant 6) |
| Management Support | Communication between management and floor staff was limited at times and lead to frustration among staff | I'm, the unit managers, so the highest after me, it's just our director of nursing. Um, and that was always good. And then our administrator, um, they honestly |

| | | |
|-----------------------------------|--|---|
| | | kinda hid out my opinion. (Participant 7) |
| | Shortages in supplies was common, including masks, gowns, soap, hand sanitizer, cleaning materials and linens | With me not being able to leave the red zone, once I was on the hall and the stuff would be elsewhere, I would have to contact someone, someone else to bring me things. And that would take awhile because they'll be doing, you know, doing their job. (Participant 5) |
| | Limited staffing was a common issue for participants | As the pandemic got on longer, you know, we got short staffed and there was new people coming back there. (Participant 3) |
| | Frustration among participants frequently stemmed from feeling forgotten or ignored when in need of assistance from management | Check on us. Just check on us, ask us if we're okay. Come back to the doors of the partition, say hello, do you need anything? (Participant 1) |
| Suggestions for the Future | Decrease the use of PPE for staff or residents | I don't think they should have to wear a mask. I mean, if this vaccine is supposed to be working, I don't feel like they should be forced to wear a mask. (Participant 9) |
| | Decrease isolation precautions to allow for wandering and socialization | I don't feel like locked down or the non-communal dining should happen in the lockdown unit. I just think that that is definitely going to make them declined in every aspect. (Participant 6) |
| | More face-to-face interaction between floor staff and management staff | The people who are making those policies aren't on the floor and they don't know what (the residents) are doing. So, I feel like if staff were better supported by management and by corporate, we might've had better outcomes. (Participant 11) |
| | Consistent caregivers for locked unit | I think the only thing that probably helped the quality of care of the rest of the residents back |

| | | |
|--|---|---|
| | | there on the locked unit was then having the same people work with them every day. (Participant 3) |
| | Increase training for the realities of a pandemic | I think, try to come up with some type of class or training with dementia from people who have dealt with the pandemic. (Participant 1) |

Table 2*Demographics*

| Credentials | Years Working in Long-Term Care |
|--------------------|--|
| CNA | 2 |
| CNA | 2 |
| PCA and CNA | 2 |
| CNA and LPN | 2.5 |
| CNA and QMA | 5 |
| RN | 9 |
| RN | 10 |
| LPN | 10 |
| CNA | 19 |
| CNA | 20 |
| | |
| Credentials | Amount Time of Training |
| PCA | 8 hours |
| CNA | 1 month |
| CNA | 1 month |
| CNA | 1 month |
| CNA | 5 weeks |
| RN | 2 years |
| LPN | 15 months |
| CNA | 2 weeks |
| LPN | 1 year |

Appendix A**Participation Requirement Flyer**

COVID-19 NURSING RESEARCH OPPORTUNITY!

Tricia Holmes is an occupational therapist who works at University Heights and is a Doctor of Health Science student at the University of Indianapolis. She is conducting research to complete her doctorate and would love your input. This research is meant to better understand the experiences of skilled nursing staff during the COVID-19 pandemic while providing care in a locked memory care unit. The purpose of this research is to explore what aspects of this pandemic have affected the quality of care we provide our residents who have moderate to severe dementia and help us learn to prepare for the next potential pandemic or other similar emergency.

Requirements to participate:

- Worked full time or part time (up to 20hrs a week) in a locked memory care unit between January of 2020 and December of 2020.
- Must be an RN, LPN, QMA or CNA
- Read and speak fluent English
- Worked day or evening shift between January of 2020 and December of 2020.

What you will be doing:

- Participate in a phone interview (lasts about 60-90 mins)
- Be available for a brief follow-up about a month later (lasts 30-40 mins).

All participants will receive a \$15 gift card for participation.

If interested:

- Call or text Tricia at (574)849-5498. Last date to contact is 3/21/2021
- If you wish to participate, you cannot participate while on the clock or on company property. It cannot affect your duties.
- CarDon does not sponsor this research. The University of Indianapolis Institutional Review Board has approved this study.
- Participation is not required for your job or any promotions.

Appendix B

Skilled Nursing Staff Experiences in Locked Memory Care Units During the COVID-19

Pandemic: Interview Guide

My name is Tricia Holmes, and I am a student at the University of Indianapolis studying to earn a Doctorate of Health Science degree. I am also an occupational therapist and have worked in skilled nursing for five years. I have specialized in treating people with dementia, specifically in locked memory care units. Today I will be conducting an interview focused on experiences of skilled nursing staff who work in locked memory units during the COVID-19 pandemic. This research will help influence further research focusing on the care provided in locked memory care units, specifically during COVID-19.

All of your responses will be kept confidential. The interview will be audio-recorded. The audio file will be stored on a password protected device and deleted after it has been transcribed. All study documents will be de-identified.

This interview will last approximately 60-90 minutes. Your participation is completely voluntary, and you may choose to not answer questions you feel uncomfortable responding to. A \$15 gift card will be provided to you as a thank you for your time and insight, after the completion of a follow-up interview that will occur about a month after this initial interview. It will be mailed to your home or can be delivered via Venmo. After this data has been analyzed, I will contact you again to review the findings. If you need to add any further information or clarification it will be added to the findings and further analyzed. Do you have any questions regarding the interview or how this data will be used? If you are comfortable, we will begin the interview.

Interview Guide

1. I'd like to start with asking a few questions about you.
 - a. How long have you worked in skilled nursing facilities?
 - b. What are your credentials or qualifications to work in a skilled nursing facility?
 - c. Why have you chosen to work on the locked memory care unit?
 - d. How do you feel about working with individuals who live in locked memory care units?
 - e. How do you feel about working with individuals who have aggressive or agitated behaviors?
2. Next, I'd like to ask about the specific training or education you received prior to the COVID-19 pandemic.
 - a. What type of training or education did you receive to gain your credentials?
 - b. What type of training did you receive to work on a locked memory care unit?
 - c. What type of training did you receive regarding PPE, hand hygiene, or isolation precautions prior to COVID-19?
 - d. How often did you have to use isolation precautions, PPE, and hand hygiene in a locked memory care unit prior to the COVID-19 pandemic?
 - e. How did you feel about utilizing isolation precautions prior to COVID-19 in utilizing PPE and hand hygiene with people who had agitation or aggressive behaviors?
3. Next, I'd like to know a bit more about your training to prepare for the realities of a crisis or pandemic.

- a. What was your experience prior to the COVID-19 pandemic in lock-down procedures?
 - i. What specific training in lock-down procedures did you have prior to the pandemic?
 - ii. How prepared did you feel prior to the COVID-19 pandemic for lock-down or quarantine procedures?
 - iii. What was your experience prior to the COVID-19 pandemic utilizing isolation gowns, N95 masks or face shield prior to the pandemic?
 - b. Would you describe the differences prior to and during the pandemic caring for people with behaviors such as wandering, agitation or aggression when they were required to be isolated?
4. Next, I'd like to talk about how you perceive the support provided from management during the pandemic.
 - a. What was your experience in the provision of PPE? Did you experience a shortage, or did you feel things were well supplied? If you experienced a shortage, what did you do to compensate for the shortage?
 - b. What was your experience in the communication between you and the management during the COVID-19 pandemic?
5. Next, I'd like to ask you a couple of questions about the policy changes enacted during the pandemic.
 - a. What were some of the policy changes you experienced to help keep you and the patients safe?

- b. What policy changes did you feel affected the quality of care provided to your patients on the locked memory care unit?
 - c. Were there any policies that you struggled to follow because of the unique population you work with?
 - i. If so, what were the policies and why did you struggle?
 - d. What aspects of providing care were the most affected by the policy changes?
 - i. How did you adapt to provide care due to these changes?
- 6. What strategies were implemented in memory care that helped improve the quality of care?
 - a. What were your experiences as strategies changed throughout the pandemic?
 - b. What policies or strategies helped improve the quality of care you provided to your patients?
 - c. What policies or strategies helped improve your response to behaviors such as wandering, agitation, or aggression during the pandemic?
- 7. Finally, I have a few questions about what suggestions you might have for the future to better provide care to people with dementia during the next pandemic.
 - a. What would you suggest to management to better support staff members and patients during a lock-down or quarantine of the unit?
 - b. What suggestions do you have for better training for future staff members when preparing for a pandemic such as the one we are experiencing?
 - c. What aspects of patient care would you suggest need to be addressed for the future to better care for patients with dementia?

- d. Is there a policy or change in how care is provided to patient's with dementia that was caused due to the COVID-19 pandemic that you believe should continue being used?
- 8. Is there anything else that you haven't shared that you would like me to know about this topic?

That is the end of our interview. Thank you so much for your time and insight on this subject. I will be contacting you again within the next couple of months for a follow-up conversation. This phone call should be much shorter, and I will be reviewing your interview and my interpretation of your interview in the context of other interviews. When we are done with the follow-up, I will be mailing you a gift card of \$15 to Amazon. If you have any questions, please do not hesitate to email me using the email in your information packet. Thank you again, have a wonderful day.

Appendix C

Themes Summary

Reasons for working on a locked memory care unit

The interview participants identified multiple reasons for choosing to work in a locked memory care unit. The majority stated they love the residents as the primary reason they decided to work with this population. The unique nature of this population was also a common theme. A few of those interviewed stated they had family members who had dementia, creating a desire to work with and help individuals with moderate to severe dementia.

Experiences working with people who have behaviors

Many participants stated that it was challenging to work with these individuals. Working on a locked unit can be emotionally draining, and some participants experienced personal injury while working with this population. Prior to the COVID-19 pandemic, a few participants noted that behaviors were less severe; however, it was also stated that behaviors were common and did increase the difficulty of working with these individuals. Participants expressed that COVID symptoms changed the residents' behaviors. For example, some participants stated the behaviors decreased as the residents began feeling unwell, while others said that symptoms seemed to increase the agitation in residents. Participants also identified that it was difficult for the residents to understand what was going on, which also increased behaviors. Participants also discussed the psychosocial effects of working with this population. Many stated that behaviors are usually triggered by changes in the environment, or the provision of care by staff. Knowing the individual resident's history or preferences helped alleviate behaviors both before and during the pandemic.

Training

Participants were asked to discuss their education and training in multiple facets of working on a locked memory care unit. This training included dementia training, hand hygiene, isolation precautions, lockdown procedures, and PPE procedures.

Most participants stated that they did not receive any specific training to work on a locked unit. However, many said they had received dementia education through online in-services provided to all employees at the facility where they work. In addition, some participants stated that they chose to receive specialized dementia training, which could range from four hours to 100 hours. However, this training was not required to work on a locked memory care unit and was elective by the participant.

Many participants stated that hand hygiene, isolation precautions, and PPE procedures were included in their training to gain their credentials. A few participants also mentioned that hand hygiene and PPE procedures were addressed with regular in-service training provided through their employer.

Training in lockdown procedures was not as common before the pandemic, leaving many participants feeling unprepared for the COVID-19 experience. While some participants mentioned that they did receive training regarding the potential for the facility to be on lockdown if there was an active shooter or bad weather, most participants stated that they received little to no training focused on lockdown procedures. As a result, most interview participants said they were not prepared for the realities of COVID-19 lockdown procedures. These procedures included limited to no visitations from family and friends and limited or no outings for the residents.

Outcomes of shared experiences

Participants had multiple changes they experienced while working on locked memory care units prior to and during the pandemic. These changes helped shape the experiences these individuals had working in this environment before the world changed due to a global pandemic.

Isolation Precautions

Before the COVID-19, pandemic isolation precautions were rarely used, but when they were, this was usually due to MRSA and C-diff. Participants stated that compliance with isolation precautions was limited because they frequently increased the residents' behaviors.

Yet, during the COVID-19 pandemic, isolation precautions were used throughout the locked unit. Many participants stated these precautions still increased the behaviors of the residents, and that over time, participants experienced a decrease in thoroughness in following the precautions. Some participants noted that the increase in residents' behaviors was due to a reduction in their social interactions with friends and family. This limited socialization seemed to increase depression in residents as well. As participants experienced the increased use of isolation precautions, such as keeping the residents in their room at all times, they experienced increased job stress when providing care to more agitated residents. The increased depression participants saw among the residents also seemed to affect how participants felt towards the precautions they were asked to utilize or enforce. Participants then experienced a decrease in their compliance with the use of PPE such as masks, face shields and gowns, as well as isolation precautions to improve the residents' quality of life.

PPE Usage

All the participants had extensive experience utilizing PPE and hand hygiene before the pandemic. However, most of their experiences were limited to the use of gloves and regular hand

washing practices. In addition, all the participants stated they had minimal experience using face masks, face shields, or gowns prior to the COVID-19 pandemic. Many of the participants also experienced increased behaviors during the pandemic with the use of face masks, face shields, and gowns. A few of the participants stated they felt this rise in behaviors was due to the resident's fear of these items and not knowing what was going on or why these items were being used.

Lockdown Procedures

All of the participants stated they had little to no experience in lockdown procedures prior to the pandemic. Only one participant said she had experienced a lockdown of a facility due to a Norovirus outbreak. This lack of experience created a lot of confusion for the participants as these procedures began being used more regularly.

Outcomes of Policy Changes

When asked about the policy changes experienced in their facilities throughout the pandemic, many participants expressed feelings of frustration. Participants were asked what policies improved the quality of care provided, with most simply stating, "none." Many participants expressed frustrations with the increased use of masks, for themselves as well as enforcing the use on residents. The participants also expressed frustration with the attempts to maintain six feet of distance between residents and isolating residents that wander to their rooms only.

Isolation Policies

For example, participants reported there was an increase in the use of isolation precautions throughout the pandemic. Before the pandemic, participants experienced one or two residents at a time being asked to remain in their room. As the pandemic progressed, the

participants were asked to keep the residents in their rooms at all times. Some stated that window visits helped limit some of the impacts of isolation precautions, such as no outside visitors. Still, one participant noted that the window visits actually increased the agitation of the residents. In addition, participants stated that isolation precautions decreased the socialization of the residents by limiting the visitation of family members.

PPE Policy Changes

Participants also experienced increased PPE usage throughout the pandemic. This included increased use of masks, with requirements to wear masks frequently changing from day to day. For example, a participant stated that she could wear cloth masks, then the policy changed to paper surgical masks, then increased to the use of N-95 masks. Masks had to be worn all day, with many participants asked to re-use the same mask for days, sometimes weeks. Face shields were also added as something that had to be worn regularly for all participants. Many participants expressed frustrations with providing care for the patients when wearing the N-95 masks and face shields. Gowns were also used more frequently, again with some participants stating they had to wear the same gown each time they entered the resident's room for an entire day.

All participants reported that the increased use of masks, face shields and gowns increased the agitation of the residents. Many participants stated that the masks limited their communication with residents. This often resulted in the participants pulling down their masks to make it easier for residents to understand or hear them, resulting in some participants decreasing their use of the masks altogether. A couple of participants had trouble enforcing the use of PPE with residents who have dementia, stating the residents would take the masks off. One participant recalled being asked to provide a mask to all residents on the memory care unit and

feeling frustrated that these masks would be wasted as the residents were not likely to keep the masks on.

Quality of Care

Participants were asked about the quality of care they were able to provide throughout the pandemic. Adaptations for providing care were regularly needed, including increased use of bed baths, tearing towels to have washcloths, and RNs and LPNs providing more assistance to the CNAs. Ensuring proper hygiene was a challenge. A decrease in the residents' hygiene was a common experience for the participants, with many stating this was due to the inability to use the common shower rooms for fear of spreading the virus. Some participants said they were happy to have more one-on-one time with the residents as isolation precautions limited the residents' ability to get out of their rooms and socialize with staff or each other. Participants would often go into the rooms and visit residents during their downtime as the staff could no longer leave the locked unit, especially when it became a Red Zone.

Red Zone Policies

All participants experienced some form of trying to separate the residents who had tested positive with the COVID-19 virus from those who had not. The area for those testing positive was called the Red Zone, with all positive residents being moved to this area to decrease the spread of the virus. Participants frequently experienced difficulties with having enough staff for two separate areas. The barriers used to create separate locations were also difficult to keep in place, with some participants experiencing residents of their locked unit tearing down the barriers or pushing through. The participants who did experience working on the Red Zone stated that it was very emotionally difficult to work on that unit. One participant recalls feeling isolated and alone as many of her residents began to pass away from the virus. Another

participant remembered experiencing feelings of depression with the residents she cared for as they lost friends to the disease.

Social Distancing Policies

Social distancing was another policy that was difficult for the participants and residents to follow. Although some participants stated that social distancing helped limit the spread of the virus, many experienced difficulties enforcing this policy with residents. Some policies were used to improve the social distancing of the residents, such as providing meals in their rooms or separating them at different tables in the dining areas. However, these policies were difficult for some participants because the residents had a limited understanding of staying away from one another. One participant told a story in which a residents would walk around the unit and eat food off other residents' trays. Another participant recalled having difficulty finding enough space to keep residents six feet away from each other in the dining room but needing to keep them out of their rooms as the residents were at risk of choking. The residents were also provided individual activities in their rooms to help keep them occupied, but this, too, was often met with difficulties as residents had problems paying attention to the items or tasks given to them.

COVID Testing and Screening

COVID-19 testing and screening were two other standard policies utilized in facilities. Some participants stated that these policies helped decrease the positive cases in the buildings they worked.

Management Support

Participants were asked multiple questions focused on their experiences regarding the support provided by the management teams at their buildings. Participants who held some level

of a managerial role throughout the pandemic reported more positive management support than those who were not.

Communication

Communication was a common theme expressed by participants that was important to their experiences during the pandemic, specifically the limited communication between management and floor staff. Some participants also expressed frustrations with the constant changing of policies. The constant changing of a policy with little to no explanations for why the change was made, frustrated participants. Participants would also find that with multiple changes enacted in such a short time there was confusion regarding what policy was to be followed. Some participants, however, did state that the communication around COVID-19 was sufficient, and these were primarily those in managerial roles.

Provision of Supplies

Provision of supplies was another common theme expressed by participants as key in their experience of COVID-19 in their facilities. Participants experienced shortages in supplies such as masks, gowns, soap, hand sanitizer, cleaning materials, and linens. Some of the participants experienced having to get supplies outside of their facilities, with some stating they would buy items on their own. All the participants said they experienced a need to adapt their supplies to accommodate the needs of the residents. These adaptations included tearing towels to make washcloths, using flat sheets for bottom sheets, making hand sanitizer with rubbing alcohol, making cloth masks at home, or tying towels around their face as a make-shift mask. Some participants said they never experienced a shortage in PPE, stating they could often find what they needed with the help of others.

Staff

Limited staffing was also a common experience among participants. Some participants stated that teamwork and consistent staff helped alleviate the limitations in staff. One participant, when asked how they dealt with the limited staffing, said they worked longer hours.

Participants also expressed frustration in feeling supported throughout the pandemic. Many participants felt that the locked unit was isolated and frequently forgotten by management. The participants also repeatedly stated that they felt misunderstood by management when policies were difficult to adhere to due to working with this particular population. For example, one participant recalled running down the hallway to retrieve a crash cart as one of her residents was no longer breathing and being stopped by someone from the corporate office to pull her mask up over her nose. Another participant recalls asking many times for items such as oxygen respirators for residents who were having difficulty breathing and never receiving a response from her supervisor.

Suggestions for Future Pandemic

The participants had a multitude of suggestions to improve the response of facilities to the next potential pandemic. One suggestion participants made to improve care in a future pandemic was to decrease the use of PPE, such as reducing the mandatory use for residents or allowing staff members to wear masks with “windows” so the residents can see their mouths when they talk. Many participants stated this was often the cause of agitation with residents.

Some suggested decreasing isolation precautions and focusing on the mental and physical health of the residents. These suggestions included increasing the time residents could go outside or allowing the residents time to who wander out of their rooms. Many participants experienced increased anxiety and depression in their residents. This led to these suggestions, with

participants expressing concerns for their resident's overall well-being when they were forced to stay locked up and isolated from friends and loved ones.

Participants suggested throughout the interviews included increased support from management. Their desire for increased face-to-face interactions with the staff providing care to the residents would help reduce feelings of being ignored or forgotten. Another suggestion was to improve the communication of policy changes, although no specific ways to do so were suggested.

Consistent caregivers for the locked unit and increased staffing were suggested from multiple participants as well. Some of the participants also suggested providing mental health support for staff from the management team specifically. This could include counseling offered to staff members or for management to give face-to-face support to staff when they have lost a resident.

Most participants also suggested increased training for the next potential pandemic, with some participants suggesting training for adaptations for providing care. Another common suggestion was for increased dementia care-focused training. Some participants also suggested increased training for the use of PPE, including how to don and doff appropriately.

Conclusions

Overall, participants experienced significant levels of stress, frustration, and feelings of having little support from management as they provided care to residents during the COVID-19 pandemic. The participants all expressed a particular love for the residents they care for. The experiences of the participants caring for this population during this extraordinary time was often influenced by fear and the unknown, with a lack of prior training or experience. These individuals worked tirelessly to provide the best care they could with a limited number of

supports and lacking needed supplies. They experienced significant changes in their residents, including increased behaviors and the loss of many of the residents they loved. Nevertheless, participants showed resilience amid the challenges they faced and provided realistic suggestions for better preparing staff for future pandemics. As this pandemic continues, the recommendations made by these individuals should be considered. Adaptations to how new staff is trained and how management can better support staff who care to a very challenging population while implementing new and difficult policies.