Understanding the Mental and Emotional Impacts of Being a Caregiver of Socially Isolated Residents During the COVID-19 Pandemic

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UNDERSTANDING THE MENTAL AND EMOTIONAL IMPACTS OF BEING A CAREGIVER OF SOCIALLY ISOLATED RESIDENTS DURING THE COVID-19 PANDEMIC

A Capstone Experience/Thesis Project Presented in Partial Fulfillment of the Requirements for the Degree of Bachelor of Science with Mahurin Honors College Graduate Distinction at Western Kentucky University

By
Chloe Kerrick
May 2022

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ABSTRACT

The mental health and emotional wellbeing of individuals has declined in many ways over the course of the COVID-19 pandemic. Some groups have seen more drastic changes in their mental health and emotional wellbeing, especially those working in healthcare. While nearly all healthcare facility workers have experienced an increased burden brought about by the pandemic, long-term care facility workers have been tasked with caring for clients that, for periods of time, experienced complete social isolation. This project will attempt to answer the question of how caring for a group of socially isolated residents over an extended period has affected the emotional wellbeing and mental health of the healthcare workers both inside and outside the workplace. Data collection for this study is generated from a survey distributed to long-term care facilities and has been completed by nursing assistants, nurses, and facility administrators. My null hypothesis for this project was that there would not be an increase in the prevalence of mental health issues as a result of caring for socially isolated residents during the COVID-19 pandemic.

Keywords: socially isolated, caregivers, long-term care, COVID-19
I dedicate this thesis to my parents, Angie, Chris, Steve, and Beth, who have always pushed me to be the absolute best I can be. Also to my siblings, Parker, Trevor, Taylor, Molly, Emilee, and Sam, who have always supported me throughout my educational journey. Lastly, I would like to dedicate this to my Nauna, who has always been my biggest cheerleader, role model, and reason why I never quit.
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INTRODUCTION

This project began because of firsthand experience in this field and a desire to dive deeper into what effects this pandemic has had on myself and my coworkers. I have worked as a state registered nursing assistant (SRNA) since May of 2017 and have over 2,000 patient care hours in a long-term care (LTC) facility. As someone that worked both before, during, and after the pandemic I experienced changes in my health and also witnessed significant effects on those I work with. Like most researchers, I initially wanted to understand the health implications on the residents themselves but as I began reviewing literature I saw a need for more insight on the direct effects of those working with socially isolated residents. My hope in starting this project was that this would open the doors for future research as to how social isolation has affected those working with the isolated individuals and lead to possible solutions on how to better address the current mental health issues in the workplace.

Social isolation is defined as the lack of social connections (CDC.gov). It has been an issue seen in the elderly population for decades—not only in those living in LTC facilities, but also people 65 and older who live alone. With an increase in regulations placed on LTC facilities, social isolation has been at an all-time high since the start of the COVID-19 pandemic (Simard & Volicer, 2020). This isolation has been connected to a decline in the emotional, social, and spiritual health of residents as well as cognitive impairment and an overall decline in the social skills for those experiencing this type of isolation (Wu, 2020).
The COVID-19 virus led to the placement of regulations that decreased the amount of social interaction for all age groups. The elderly population, people aged 65 and older, were especially affected as they were placed into a high-risk category which led LTC facilities to place heavy regulations on the social interactions allowed between residents, family members, and other visitors. Before the pandemic, LTC facilities welcomed residents to have family and other visitors in the facility whenever they desired. However, in April of 2020, the majority of LTC facilities closed their doors to the public in an effort to protect the high-risk population living inside the facilities (Wu, 2020).

While researchers have continued to look at the implications this isolation has placed on the residents, few have looked into the impact on the caregivers providing for the residents who suddenly found themselves totally isolated from contact with family and friends. Facilities were forced to close their doors and only allow employees and necessary healthcare providers inside which meant the only person-to-person interaction many residents had was with those providing for them. It has been a year and a half since these regulations were implemented and most facilities are still only allowing residents to visit with friends and family through phone calls, facetime calls, and window visits. Meaning that for a year and a half, LTC facility employees have held the responsibility of being the only face-to-face social interactions residents have had.

The Total Person Concept (TPC) was developed by Leadership Management International (LMI) and identifies 6 areas of an individual's life that come together to make them a total person: mental, social, physical, spiritual, family, and financial (2021). When all of these components are in harmony the individual is said to enjoy a high level
of wellness. When any of these components is lacking, it causes dissatisfaction, discomfort or worse. Caregivers and medical personnel of this high-risk population were undoubtedly impacted in many of these aspects because of the pressure placed on them during the COVID-19 pandemic. While each of the six areas identified by LMI are important, this project looks specifically at the mental sector and what plays into individuals' lives.

The need for information on the effects this social isolation is having on the residents themselves is already under study (Chu et al., 2021), but this project observes the effect on those who are care providers. Unlike the residents, the caregivers are able to leave work and live a more normal life than what their residents are living within the facilities. Inside work they are now tasked with not only providing physical care for their residents but also by default providing social interaction as they may be the only face-to-face interaction the residents have for the entire day. This social interaction is not something new as a result of the pandemic, but the change has been in the caregiver recognizing the additional need for social interaction with residents. According to an article published in The Gerontologist, “Most respondents were involved in caregiving before nursing home placement (67%), with many involved for more than 1 year (43%). The majority of caregivers (80%) lived less than 16 miles from the nursing home where their relative lived, and most caregivers (76%) visited their relative in the nursing home at least weekly” (Torontore & Grant, 2002). This means that a large portion of residents got a good amount of social interaction from family and friends when they came to visit. The pandemic forced these numbers to drop to 0% because of state and national regulations put in place regarding in person visits. However, their need for around the
clock care did not stop, meaning that time that they were in contact with a worker at the
certainty may be one of the only times they were able to see another person that day.

The COVID-19 is ongoing and current, which makes research about this topic and
surrounding it, new and limited. This thesis will use existing information along with a
new set of data to analyze how caring for socially isolated individuals impacts the
caregiver. Using the Total Person Concept this project will focus on one of the six TPC
components that come together to make a total person, the mental aspect (2021). Since
this topic is new, the goal is to identify and better understand the mental and emotional
impacts on caregivers to expand research into this topic.
LITERATURE REVIEW

Mental and emotional health in the workplace is not a new topic, it is one that has been researched for decades across all professions (Goetzel et al., 2018). The COVID-19 pandemic has shed light on the mental and emotional health of healthcare professionals (Spoorthy, Pratapa, & Mahant, 2020). This is attributed to the fact that during the peak of the pandemic, healthcare facilities experienced a spike in patients which increased the workload and job responsibilities for those working within these facilities. However, in addition to reduced staff and increased workloads LTC workers also were cast into the role of surrogate family member. Few, if any, other healthcare workers were expected to serve in this role for long periods of time. Mental and emotional health in long term care workers during the pandemic is new and therefore research in this area is scant. This review looks at this topic on a broad perspective to provide background for the topic. This section will identify literature that has looked into the effects of mental health issues and possible intervention methods across all healthcare facilities and not just those working within long term care during the pandemic.

The Asian Journal of Psychiatry published a review in 2020 that stated there was evidence supporting COVID-19 as an individual risk factor for stress in health care workers (HCW) (Spoorthy, Pratapa, & Mahant, 2020). This review highlighted that because healthcare personnel are the primary caretakers for those with COVID-19, it has led to added stress, likelihood of disease both COVID-19 and others, and negative
psychological impacts (Spoorthy, Pratapa, & Mahant, 2020). The virus's high infection rates have also put many providers in the patient seat which is not a role many are familiar with and can lead to even more added stress. This article brings attention to an issue that has been going on for decades but is more apparent in light of the pandemic, a lack of emphasis on the overall health of healthcare workers. The conclusion of this review was that there needs to be more screening and observation for healthcare workers treating and diagnosing COVID-19 patients that evaluates their stress, depression, and anxiety levels (Spoorthy, Pratapa, & Mahant, 2020). While this is a good intervention for those specifically involved with COVID-19 patients, it is an intervention that can be applicable to HCW across a number of specialties.

Another article published by Chirico et al. in 2020 highlighted many of the same factors as the previous manuscript but also emphasized that a primary cause of mental and emotional health issues in the workplace could be a direct result of being unprepared prior to the pandemic (Chirico, Nucera, & Magnavita, 2020). Authors pointed out that mental health issues were already prevalent in HCW before the pandemic but have just heightened since the beginning of COVID-19. This brings up the issue of how they would have responded to the pandemic if their previous mental health issues had been treated when they first started. There were not the necessary resources beforehand which meant when things got worse, many HCW did not know how to cope.

LaMontange et al. published an article in 2014 that describes the best way to address mental health issues that can result from workplace stressors as a result of caring for individuals during the COVID-19 pandemic (LaMontange et al., 2014). The overarching theme is that medicine, public health, and psychology must come together to
address issues in the workplace (LaMontange et al., 2014). This article emphasizes that you cannot fix or combat all mental health issues using the same tactic, meaning it must be addressed using several different approaches and multiple disciplines. One significant part of this article is the value placed on the different sectors of healthcare to work together to address both mental and emotional health issues seen in the work environment (LaMontange, et al., 2014).

The sector approach identified in BCM psychiatry can be applied specifically to healthcare workers using some of the intervention techniques highlighted in the article found on BMJ (Greenberg et al., 2020). This article discusses how healthcare personnel can take mental health into their own hands through self-care techniques that will help ease the stressors associated with being and HCW. This article highlights how necessary it is that facilities be open about the difficulties associated with working in healthcare in today's time while also providing individuals with screening, support, and treatment when necessary (Greenberg et al., 2020). Another key point in this analysis by Greenberg et al. is the idea of moral injury among healthcare workers starting early on and how it can play a part in the development of certain mental health issues. This concept coincides with the prevention aspect of public health mentioned in LaMontagne et al. in 2014.

In 2021, a review of healthcare personnel in Spain and after the causes of psychological issues were identified they looked into the effectiveness of the intervention methods used (Priede et al., 2021). Since the pandemic is a new and ongoing public health issue, the observation into the effects on HCW is very new and ongoing. This analysis looked at 36 different hospitals and identified most interventions working towards emotion regulation with online and in person therapy (Priede et al., 2021). The
in-person sessions targeted mindfulness and psychoeducation and were usually run by workers within the facility (Priede et al., 2021). The problem identified in this study is that very few of these facilities were given proper training on how to conduct the sessions they were leading and conducting for people suffering from mild to severe mental health issues. There was not enough emphasis on the importance of these interventions because in many cases they were just being rushed to implement and not conducted properly. While many healthcare workplace training is in place, specific training regarding the pandemic and how to cope with it were a new idea.

The last source used to evaluate this mental and emotional health issue is one that looks at workplace mental health interventions and the effect they have on productivity (Wagner et al., 2016). While many studies have started identifying the specific mental health implications, few have identified how to transition individuals struggling with this issue back into the environment. The article concluded that there was moderate evidence that supported most of the interventions described, however, “those incorporating both mental and physical health interventions, multicomponent mental health and/or psychosocial interventions, and exposure in vivo containing interventions” were found to be the most effective and have the best results (Wagner et al., 2016). Findings from this article reinforce previously mentioned sources that multiple disciplines should be involved to assist workers in facilities that are struggling with stress related mental health issues (Wagner et al., 2016). While this approach is not specific to healthcare workers, the ideas behind effective intervention and treatment are similar to those needed in healthcare facilities.
METHODOLOGY

Study Design

This research project utilized paper surveys as the primary tool for data collection. The survey consisted of 42 questions and included both continuous and categorical questions. The survey was created by adapting existing mental health and workplace surveys and new questions were created using information collected during the literature review. The survey distributed among participants was the same for all individuals to ensure uniformity during the data analysis. Of the 42 questions, 2 were continuous and 40 were categorical. The first 10 questions were demographic questions used to identify characteristics of the study population. The next 7 questions asked about the time worked since April of 2019 to get an idea of participants' workplace environment during the pandemic. The next 9 questions asked them about individuals' overall mental health both inside and outside of work in the past 12 months. In this section participants were asked to answer either “very good,” “good,” “neutral,” “not good,” or “very not good” for how they felt regarding the statement. The next 9 questions were in regards to their mental health working before the pandemic and during. In this section participants could select “very true,” “true,” “neutral,” “not true,” or “very not true.” The last 7 questions asked questions about their overall mood in the past month both inside and outside the workplace.
The null hypothesis for this project was that there would not be an increase in the prevalence of mental and emotional health issues as a result of being a caregiver to socially isolated residents during the COVID-19 pandemic. The research hypothesis was that there would be an increase in the prevalence of mental and emotional health issues as a result of being a caregiver to socially isolated residents during the COVID-19 pandemic. Data analysis was done using Statistical Analysis Software (SAS), which is used to analyze data and write reports. An excel spreadsheet was made of the 42 survey questions using codes for each question and a data code dictionary. The excel spreadsheet was then input into the SAS software and frequency codes were run for each question.

Population

The mean age for this study was 42.58 years of age with ages ranging from 21 to 71. Of the study population, 7 (22.58%) identified as male and 24 (77.42%) identified as female. There were 8 administrators (25.81%), 7 nurses (LPN and RN) (22.58%), 14 state registered nursing assistants (45.16%), and 2 that selected “other” (6.45%). One that selected the other worked in housekeeping and one worked in the dining services. 28 of the participants (90.32%) selected that they were “not of Hispanic, Latino, or Spanish origin,” 2 participants (6.45%) selected “Puerto Rican,” and 1 participant (3.23%) selected “Mexican, Mexican American, Chicano.” For education status, 1 participant (3.23%) selected “less than high school,” 2 participants (6.45%) had “some high school,” 7 participants (22.58%) was a “high school graduate or equivalent,” 10 participants (32.26%) selected “some college, but degree not received or is in progress,” 6 participants (19.35%) had an “associate degree,” 2 participants (6.45%) selected a “bachelor degree,” and 3 of the participants (9.68%) selected having a “graduate degree.”
When asked their marital status: 17 (54.84%) selected “now married,” 1 (3.23%) selected “widowed,” 3 (9.68%) selected “divorced,” and 10 (32.26%) selected “never married.” Of the 31 participants, 30 (96.77%) identified as “straight, that is not gay or lesbian” and 1 (3.23%) identified as “gay or lesbian.” The largest number of participants, 17 (54.84%), selected working in this position for “5 years or longer,” then 5 (16.13%) selected “3 to 4 years,” 4 (12.90%) selected “6 months or less,” followed by 3 (9.68%) who selected “1 to 2 years,” and then 1 (3.23%) that selected both “2 to 3 years” and “4 to 5 years.”

Table 1: (above) This table shows a visual representation of how participants responded to the categorical question, “What is the highest degree or level of school you have completed?” In the first column, 1 represents “Less than high school,” 2 represents “some high school,” 3 represents “High school graduate or equivalent (for example GED),” 4 represents “Some college, but degree not received or is in progress,” 5 represents “Associate degree (for example AA, AS),” 6 represents “Bachelor degree (for example BA, BS, AB),” and 7 represents “Graduate degree (for example masters, professional, doctorate).”
Table 2: (above) The table shown represents how respondents answered the question, “How long have you worked in this position?” Row 1 represents respondents who answered “6 months or less,” 3 represents “1 to 2 years,” 4 represents “2 to 3 years,” 5 represents “3 to 4 years,” 6 represents “4 to 5 years,” and 7 represents “5 years or longer.” One important note with this table is that more than 75% of the study population has worked the position for more than 3 years. This means they worked before the pandemic and know the difference between the workplace before the pandemic and during.
Table 3: (above) This table represents 4 of the demographic questions asked in the survey. The table does not show non-responders. The 31 participants ranged from age 21-70 with a mean age of 42.58. There were two races represented in the sample population: White (64.52%) and Black or African American (35.48%). The majority of participants either had some college education (32.36%), were high school graduates (22.58%), or had completed an associate’s degree (19.35%). Most participants are either now married (54.84%) or have never married (32.26%).
RESULTS

This section uses descriptive analysis to identify the questions with the most important responses in regards to answering the research question, “Is there a decrease in the mental and emotional health of long-term care workers as a result of working with socially isolated residents during the COVID-19 pandemic?” This section does not report the responses to every question asked in the survey, only those with meaningful responses to answer the research question.

Following the demographic questions, the next 7 questions were categorical questions that asked participants about their time working from the start of the pandemic up until the present. In this section, 20 participants (74.19%) worked throughout the entire pandemic and 11 participants (35.48%) did not work the entire time. Of the 31 participants, 18 individuals (58.06%) typically worked 8-hour shifts, 10 individuals (32.26%) worked 12-hour shifts, 2 individuals (6.45%) worked 16-hour shifts, and 1 participant (3.23%) worked both 8- and 12-hour shifts. Next, they were asked, “How often during your typical shift are you interacting with the residents?” Eighteen (18) participants (58.06%) answered “the majority of my shift,” 3 (9.68%) answered “most of my shift,” 4 (12.90%) answered “at least half of my shift,” 4 (12.90%) also answered “less than half of my shift,” and 2 (6.45%) answered that they “rarely interact with the residents.” The last question in this section asked about their job responsibilities while at work: 12 (42.86%) responded “helping residents with activities of daily living,” 5
(17.86%) responded “medication distribution,” 4 (14.29%) answered “charting,” 4 (14.29%) responded “work in an office or at a desk,” and 3 (10.71%) answered “other.”

One important thing to note in this question is that the largest number of participants reported that their primary job responsibility is helping residents with activities of daily living (ADLs). This means the residents are in need of anywhere from complete assistance to limited assistance when performing certain everyday tasks.

Another thing to observe is that over 50% of respondents answered that they spend the majority of their shift interacting with the residents. This is significant because during the pandemic doors were closed to everyone except the caregivers working in the facility, so the time they are interacting with the residents is often the only in-person contact some of these residents have.

**Table 4:** (above) This table shows the frequency and percent of the participants' responses to “Which best describes your job responsibilities while at work?” In the first column, 1 represents “Helping residents with activities of daily living (dressing, eating, walking, bathing, etc.),” 2 represents “Medication distribution,” 3 represents “Charting,” 4 represents “Working in an office or at a desk,” and 5 represents “other.”
Table 5: (above) This table shows the frequency and percentage of the responses to “How often during your typical shift are you interacting with the residents?” In the first column, 1 represents “The majority of my shift,” 2 represents “Most of my shift,” 3 represents “At least half of my shift,” 4 represents “Less than half of my shift,” and 5 represents “I rarely interact with the residents.”

The next set of questions asked about participants' overall health and mood while at work and outside of work in the past 12 months. There were 9 questions in this section where participants could respond “very high,” “high,” “neutral,” “low,” or “very low.” Four of the 9 questions showed important results in the way participants responded. When asked to rate their overall well-being levels while at work, 3 (9.68%) answered “very high,” 14 (45.16%) answered “high,” 13 (41.94%) answered “neutral,” and 1 (3.23%) answered “low.” When asked to rate stress levels at work, 8 (25.81%) responded “very high,” 14 (45.16%) responded “high,” 8 (25.81%) responded “neutral,” and 1 (3.23%) responded “low.” The next question asked how participants would rate their mental health at work: 1 (3.23%) answered “very high,” 11 (35.48%) answered “high,” 12 (38.71%) answered “neutral,” 5 (16.13%) answered “low,” and 2 (6.45%) answered “very low.” The last question that showed importance in this section asked about participants mental health outside of work: 11 (35.48%) responded it was “very high,” 10
(32.26%) responded “high,” 8 (25.81%) responded “neutral,” and 2 (6.45%) responded “low.” The responses to this section of questions is represented in the table below.

Table 6: (above) One interesting note about these responses is that >50% reported “very high” and “high” stress levels at work while also reporting “very high” and “high” well-being levels (>54%). The other interesting note is looking at the difference in how they reported their mental health inside and outside of work. Only 38.71% rated their mental health as “very high” or “high.” However, outside of work, 67.74% of the sample population said their mental health was either “very high” or “high.”

The next set of 9 questions asked only the participants who worked before April of 2019 and have worked at least 6 months from April 2019 to the present to participate. Of the 31 participants, only 29 responded to this section of questions. Respondents were asked to answer “very true,” “true,” “neutral,” “not true,” or “very not true” in this section. Four of the questions showed important responses in regards to the research.
question in this study. When asked if their facility has had staffing issues during the pandemic, 25 (86.21%) responded “Very true,” 2 (6.90%) responded “True,” and 2 (6.90%) responded “neutral.” This is important to note because previous studies have identified staffing issues as a reason for increased workload and increased workload as a cause of an increase in stress and a decrease in mental health. The next question asked if their workload had increased: 19 (65.52%) responded “very true,” 6 (20.69%) responded “true,” and 4 (13.79%) responded “neutral.” The next question asked respondents if they found themselves more emotional at work than before the pandemic: 8 (27.59%) said “very true,” 4 (13.79%) said “true,” 11 (37.93%) said “neutral,” 4 (13.79%) said “not true,” and 2 (6.90%) said “very not true.” The last question that yielded important responses in this section asked respondents if they felt their mental health had declined since the start of the pandemic: 9 (31.03%) responded “very true,” 7 (24.14%) responded “true,” 7 (24.14%) responded “neutral,” 5 (17.24%) responded “not true,” and 1 (3.45%) responded “very not true.” This means that over 50% of respondents felt that they had seen a decline in their overall mental health as a result of working during the pandemic.
Table 7: (above) Represents 4 questions relating to changes in mental health during the COVID-19 pandemic. Two participants did not complete this section because they did not work before the pandemic. Key points in this section are that 86.21% (25) of participants said their facility had a staffing issue and that same percent said it was either “very true” or “true” that they had an increased workload.
CONCLUSION

After analyzing the data from the survey and using descriptive analysis, it can be concluded that I can reject my null hypothesis and fail to reject my research hypothesis. This means that based on the results of the survey there was evidence to suggest that there was an increase in mental and emotional health issues as a result of being a caregiver in long term care facilities to socially isolated residents during the COVID-19 pandemic. This conclusion is based on the results to a specific group of questions in the survey. Due to time constraints and the fact that this is an undergraduate research project, only a descriptive analysis was used to analyze the data. This conclusion identifies that there is a need for change within the study population.

There were a number of questions that yielded meaningful results and played into the conclusion identified above regarding this research project. The two primary sections of questions with the most prevalent results were questions 18-26 and questions 27-35. In the first set of questions, the survey found that over 50% of respondents rated that their stress was very high or high and another 41.94% answered the question as feeling neutral. This means that only one individual in the entire study felt that they had low stress at work. Stress in the workplace is normal and, in some cases, can be healthy. However, extended bouts of distress are not something that should be happening consistently and without intervention. A recent article posted this year stated, “A certain amount of stress is a normal part of daily life. Small doses of stress help people meet deadlines, be
prepared for presentations, be productive and arrive on time for important events.

However, long-term stress can become harmful. When stress becomes overwhelming and prolonged, the risks for mental health problems and medical problems increase” (CAMH, 2022). The article goes on to identify what mental health implications can result from stress such as anxiety, depression, substance abuse, sleep issues, and many other things. If only one in 31 individuals identified low stress in their workplace, it can be concluded that a large portion identifies stress as a major part of their job.
DISCUSSION

This study yields new information on what effects caring for those socially isolated has had on the mental and emotional well-being of LTC staff members. Other researchers can use this study to address future issues surrounding healthcare workers caring for socially isolated residents. There are currently very few studies that assess the risk factors for those working in LTC facilities. The purpose of this study is to provide new information that will affect the impact of working in LTC facilities, and provide recommendations to improve the caregivers' mental and emotional well-being during periods of extended isolation. After data analysis is completed, past studies will be used to suggest possible effective intervention methods for those negatively impacted by caring for socially isolated residents.

There are a few things that should be focused on in future research. The first thing is increasing the sample population that takes the survey which will increase the amount of quantitative data available. The sample size being 31 in this study did place limitations as to how representative this research was. The next step would be collecting more qualitative data to support the quantitative data collected. This could be accomplished through one on one interviews with the caregivers, their families, or facility managers. This information will allow researchers to identify the primary causes of the decrease in overall mental and emotional health. Last, future studies should test the possible intervention methods within facilities and make recommendations on the most effective
methods. While every facility will have different causes, broad intervention methods can be used to start training the facilities on prevention methods.

The first thing that needs to be looked at moving forward in the facilities themselves is what is the primary cause for stress in long term care facilities caregivers. This survey identified that there was high stress in the workplace among most respondents. It also concluded that there was an increase in workload for caregivers since the start of the pandemic. The question then becomes is there a connection between these two facts. It can also be said that some of the responsibilities of the caregivers shifted as a result of the pandemic. This also needs further research that can identify if this is one of the primary causes of stress among HCW. It would also be beneficial for further research to collect more qualitative data to best address some of these questions. This could be done through conducting surveys that ask for information as to why they have felt changes in their mental and emotional health.

After increasing the population size for this study and identifying possible connections between specific stressors, facilities need to look into how to manage this ongoing issue. While the pandemic may not be a part of the workplace forever, the effects on workers mental health is not something that will just go away. The recommendations as to possible intervention methods for the facilities and the health care workers within them are based on previous methods used within other facilities. LaMontange et al.’s article published in 2014 does the best job at summing up how as a society to address this through using multiple disciplines and sectors of healthcare (LaMontange et al., 2014). This article places an emphasis on an “integrated intervention approach” that uses not only medicine but also a public health approach and psychology
to address the mental and emotional health issues seen in HCW (LaMontange et al., 2014). This means before prescribing a specific approach to combat an issue, facilities identify exactly what is going on with each specific worker. Then determine whether medicine, therapy, time off, etc. is what that individual needs.

Not only do facilities need to identify current mental and emotional health issues within their facilities, they also need to work to prevent it from continuing to happen. LaMontange et al., 2014 stated, “To realize the greatest population mental health benefits, workplace mental health intervention needs to comprehensively 1) protect mental health by reducing work–related risk factors for mental health problems; 2) promote mental health by developing the positive aspects of work as well as worker strengths and positive capacities; and 3) address mental health problems among working people regardless of cause” (LaMontange et al., 2014). The first part of this statement is where the public health approach comes in. Prevention is the backbone of public health practice and a bridge between this sector and the clinical side of medicine is crucial in working towards ending this problem. One example of how facilities can achieve this is through being transparent with applicants when they apply. If they are aware that mental and emotional health is currently low within their facilities, that should be portrayed to potential applicants so they are not blindsided when they begin working.

The next intervention method is for caregivers and other health care workers to take the problem into their own hands. Only 2 of the 31 participants (6.45%) in this survey answered that they had received counseling or therapy to combat the identified mental health issues within the past month. Unfortunately, until facilities are given the resources and training to address these issues, workers may be forced to seek help on
their own. In the meantime, being open with administrators and those in positions of power about what is causing their stress and what the facility can do to help them is a good next step.

The most important thing to understand moving forward as a society is that when addressing this ongoing issue, one size does not fit all. While health care workers are experiencing many of the same mental and emotional health issues as a result of the pandemic, they are not experiencing all the same things. The causes of their mental and emotional health issues are different and therefore must be addressed differently. This problem needs to be addressed from a multi-disciplinary approach that takes into account a wide variety of ways to address this issue. This project did not answer every question, in fact it likely created more, however, this was the purpose of the project in order to open the doors to future research that will go on to answer these questions.
REFERENCES


