EVIDENCE SYNTHESIS BRIEFING NOTE

TOPIC: **THE WELLBEING OF RESIDENTS IN LONG-TERM CARE HOMES DURING THE COVID-19 PANDEMIC**

Information finalized as of March 31, 2021.[a]

This Briefing Note was completed by the Research, Analysis, and Evaluation Branch (Ministry of Health).

Purpose: This briefing note provides a summary on the wellbeing of long-term care home (LTCH) residents during the COVID-19 pandemic.

Key Findings and Implications:

- **Deteriorated Wellbeing of LTCH Residents:** Physical isolation and quarantining in LTCHs are commonly identified IPC practices contributing to the deteriorated wellbeing of residents. There are seven identified wellbeing domains that are negatively affected by physically isolating/quarantining in LTCHs during the COVID-19 pandemic:
  - Decline in mental health (i.e., depression, delirium, loneliness, and mood/behavioural problems);
  - Multiple wellbeing domains declining simultaneously (i.e., decline in physical, functional, cognitive, and mental health; weight loss; and urinary incontinence);
  - Increase medication use;
  - Decline in cognition;
  - Increase in social isolation;
  - Increase in loneliness; and
  - Increase in care dependency.

- **Recommendations Addressing the Deteriorated Wellbeing of LTCH Residents:** Increasing the social interaction, communication, and socialization of LTCH residents are commonly identified recommendations addressing their deteriorated wellbeing. Recommendations include:
  - Technological innovation (i.e., inteRAI, video chat, use of iPads, telehealth); increasing visitor time and frequency in accordance with public health measures (i.e., physical distancing, face masking);
  - LTCH staff training on common mental health disorders; using different therapies and interventions to address social isolation (e.g., music therapy, cognitive and behavioural therapy, mindfulness-based stress reduction, meditation);
  - Prioritizing vaccination for resident family caregivers and LTCH staff; and
  - Continuing daytime activities.

Implications for Ontario:

- The risk of confinement syndrome has increased in LTCH residents during the COVID-19 pandemic. Confinement syndrome includes social networks and support systems being disrupted; access to health and/or social programming being reduced; less mobilization and activity occurring due to fear of contracting the disease; and staff being less available to provide care due to staffing challenges. No recommendations for addressing the social isolation of LTCH residents were identified.

[a] This briefing note includes current available evidence as of the noted date. It is not intended to be an exhaustive analysis, and other relevant findings may have been reported since completion.

Supporting Evidence

Table 1 below summarizes scientific evidence and jurisdictional experiences on the wellbeing of LTCH residents during the COVID-19 pandemic. In terms of jurisdictional experience, information is presented on Canada (Ontario, New Brunswick), Australia, Europe, France, Latin America, Netherlands, and the United States (US) (Connecticut, Florida). All of the information identified on the wellbeing of LTCH residents pertains to the IPC practices of physical isolation or quarantining in LTC settings.

Additional details are provided in Table 2 (wellbeing of LTCH residents during the COVID-19 pandemic) in the Appendix.

Table 1: Summary of Scientific Evidence and Jurisdictional Experiences on the Wellbeing of LTCH Residents During the COVID-19 Pandemic

Scientific Evidence	**Wellbeing of LTCH Residents** • **Mental Health (New Brunswick, France, Europe, Latin America, Netherlands):** LTCH residents have developed or are experiencing deteriorated mental health conditions (e.g., depression, delirium, loneliness, and mood/behavioural problems). Factors that may contribute to deteriorated mental health in LTCH residents include: social Isolation (i.e., restricted communal dining, social distancing during the death of a fellow resident); limited family contact; care dependency on caregivers whose time is now occupied with increased workload, shortages in equipment and supplies, and increased postmortem care; and lack of stimulation from social activities.[1,2,3,4] • **Changes to Multiple Wellbeing Domains (Canada, US [Connecticut]):** The physical and/or quarantine restrictions in LTCHs may result in multiple wellbeing domains being negatively affected simultaneously (i.e., physical, functional, cognitive, and mental health; weight loss; and urinary incontinence).[5,6] • **Medication Use (Europe, Latin America):** Dementia residents may experience an increase in prescription of antipsychotics and benzodiazepines for psychological conditions experienced during LTCH lockdowns.[4] • **Cognition (Europe, Latin America):** Dementia residents are likely to experience a cognitive decline during the lockdown.[4] • **Social Isolation (Europe, Latin America, US [Connecticut]):** Social isolation (i.e., reductions in direct care provision, policies that restrict visitors) contributes to a decline in LTCH resident wellbeing. Despite technological innovations like video calls and creative solutions (e.g., plexiglass partitions) being implemented, residents are likely to continue experiencing socially isolation.[4,6] • **Loneliness (Netherlands, US [Florida]):** Although prohibiting group activities decreases the risk of spreading the COVID-19 infection in LTC settings, it significantly increases the isolation and resulting loneliness in LTCH residents.[7,8] • **Care Dependency (US, Connecticut**): The COVID-19 outbreak may exacerbate the challenges associated with existing staff availability for resident direct care provision. Furthermore, LTCH visitor limitations prevent family members and other unpaid caregivers from providing important supplemental care to LTCH residents.[6] **Recommendations to Addressing Deteriorated Wellbeing** • **Technological Innovation (New Brunswick, US [Florida]):** Evidence-based clinical information systems supporting the surveillance of mental health outcomes, and evaluation of strategies to improve socialization (e.g., inteRAI) are recommended to address the compromised wellbeing of LTCH residents.[2,9]

	• **Visitors (Canada, EU, Latin America, Netherlands):** Increasing visitor time and frequency can improve the wellbeing of LTCH residents.[1,4,5] Best practices include:
	  o Number of Visitors Permitted (Canada):
	  ▪ *Outdoors*: Outdoor visits can include more than one visitor at a time, provided that physical distancing can be maintained.[5]
	  ▪ *Indoors:* One visitor per resident in the LTCH at a time is recommended.[5]
	  o Location of Visits (Canada): Outdoor visits should be prioritized, when possible and feasible, to minimize the risk of COVID-19 transmission and to maximize the number of visitors. When outdoor visits are not feasible for either the resident or the visitor (e.g., for cognitive, psychiatric, or physical reasons), the LTCH must provide an indoor alternative that provides ample open space for physical distancing and adequate ventilation.[5]
	  o IPC/Personal Protective Equipment (PPE) (Canada, Europe, Latin America): Visitors must remain masked at all times and maintain at least two metres of physical distance from the resident. Visitors should be encouraged to bring their own cloth masks for outdoor visits. LTCHs should maintain ample PPE supply to enable resident visits.[4,5]
	• **Staff Training (France):** Programs should be offered to train and educate caregivers on how to deal with the mental health disorders of LTCH residents.[3]
	• **Therapy and Interventions (France, US [Connecticut]):** Psychological therapies (e.g., cognitive and behavioural therapy, mindfulness-based stress reduction, meditation) and target interventions can be used to address the deteriorated mental health and negative impact of social isolation on LTCH residents.[3,6]
	• **Vaccination (Europe, Latin America):** Family caregivers and LTCH staff should be prioritized to receive the COVID-19 vaccine. Of particular importance is offering vaccines to LTCH staff when they can access it (i.e., during work shifts).[4]
	• **Activities (Netherlands):** LTCHs should implement policies that permit continuing daytime activities.[1]

International Scan	**Wellbeing of LTCH Residents** • **Social Isolation (Australia, US [Florida]):** Social isolation (i.e., being confined to LTCH rooms without congregate dining, activities, and in-person family visits) may lead to distress among LTCH residents, as it limits: physical activity; direct sunlight and fresh air; levels of social interaction; and access to medical, mental health, and other therapeutic services.[9,10] • **Changes to Multiple Wellbeing Domains (Australia):** The physical and/or quarantine restrictions in LTCHs can result in multiple wellbeing domains being affected simultaneously (i.e., physical and mental health). Limited physical contact, exercise, and fresh air may adversely affect residents' mental and physical health.[10] • **Care Dependency (US Florida):** According to a Psychiatric Times commentary (Nov 11, 2020) on the impact of COVID-19 on mental health in LTC settings, the majority of LTCH residents may not be tech-savvy or tech-capable, making them fully or passively reliant on the time and availability of staff to facilitate video chats and interaction with family and friends.[9] **Recommendations to Addressing Deteriorated Wellbeing** • **Technological Innovation (US, Florida):** Telecommunication devices intended to increase communication with family members (e.g., video chats, iPads), and health care practitioners (HCPs) (e.g., telehealth) may address LTCH residents' experience of social isolation.[9]

	• **Visitors (Australia, US; Florida):** Communication and contact with family and community members can be facilitated through drive-thrus and are recommended to be used in conjunction with other public health measures (i.e., mask wearing and physical distancing).[9,10] • **Therapy and Interventions (US; Florida):** Programming (e.g., music therapy) can be used to address the deteriorated mental health and negative impact social isolation has on LTCH residents.[10]
Canadian Scan	**Wellbeing of LTCH Residents** • **Social Isolation:** Physical distancing in LTCHs may lead to increased incident cases of mental disorders that may go undetected and untreated. Physical distancing may also create an increased sense of isolation in LTCH residents, which is identified as a risk factor for depression and cognitive impairment.[11] • **Mental Health:** LTC residents describe their experiences during the course of the pandemic as devastating, emotional, terror awakened, muzzled, trapped, broken-spirited, and boredom.[12] **Recommendations to Addressing Deteriorated Wellbeing** • **Technological Innovation:** In lieu of providing on-site support during the COVID-19 outbreak, psychogeriatric teams can provide digital support. For example, digital access to behavioural support specialists who are on call and can provide rapid consultation. Tablets can be used by LTCH staff and family members, to observe, support, and interact with residents who are in physical isolation due to infection. Current challenges associated with this technological innovation is the availability of devices and uneven Wi-Fi connection.[12] • **Staff Training:** LTC facilities should provide staff with training in assessing and managing common mental health disorders such as delirium and depression, management of neuropsychiatric symptoms, and responding to emergent mental health crises. These training programs require access to trainers, as well as resources to allow staff to attend these courses as part of their paid employment, while ensuring an adequate number of staff are available to support the ongoing needs of LTC residents.[12]
Ontario Scan	**Wellbeing of LTCH Residents** • **Social Isolation:** The risk of confinement syndrome has increased among LTCH residents during the COVID-19 pandemic. Confinement syndrome includes social networks and support systems being disrupted, including the support provided by essential caregivers and visitors in hospitals and congregate settings; access to health and/or social programming that have been reduced, including less in-person contact/ assessment and fewer activities/programs; less mobilization and activity occurring due to fear of contracting the disease, physical distancing across settings, and reductions in programming; and usual staff being less available to provide care due to staffing challenges and IPC demands, including additional time required for PPE.[13] **Recommendations to Addressing Deteriorated Wellbeing** • No information identified.

Methods

The COVID-19 Evidence Synthesis Network is comprised of groups specializing in evidence synthesis and knowledge translation. The group has committed to provide their expertise to provide high-quality, relevant, and timely synthesized research evidence about COVID-19 to inform decision makers as the pandemic continues.

For more information, please contact the Research, Analysis and Evaluation Branch (Ministry of Health).

Table 2: The Impact of the COVID-19 Pandemic on the Wellbeing of LTCH Residents[b]

Jurisdiction / Institution or Type of Source Document / LTC Setting	IPC Practice	Reported Outcomes on the Wellbeing of LTCH Residents	Recommendation/Best Practices
Canada, Ontario **North Simcoe Muskoka** **Health Care Setting**	• Physical isolation or quarantining in a LTC setting	• **Social Isolation:** According to a North Simcoe Muskoka webpage on confinement syndrome, the protection measures put in place to enhance safety during COVID-19 have led to either the directed or chosen confinement of many older adults and caregivers. As a result, the risk of confinement syndrome in these individuals is increased because: social networks and support systems have been disrupted, including the support provided by essential caregivers and visitors in hospitals and congregate settings; access to health and/or social programming has been reduced, including less in-person contact/assessment and fewer activities/programs; less mobilization and activity is occurring due to fear of contracting the disease, physical distancing across settings, and reductions in programming; and usual staff who 'know' the older adult (i.e., their needs and their environment) have been less available to provide care due to staffing challenges and IPC demands, including additional time required for PPE.[13]	• No information identified.
Canada, New Brunswick **Study** **LTCHs**	• Physical isolation or quarantining in a LTC setting	• **Mental Health:** According to a study (January 2021) on evaluating the effect of the COVID-19 pandemic lockdown on LTC residents' mental health, LTC homes have been closed or "locked down" to all visitors including family and friends to maintain physical distancing measures and decrease viral transmission. Even in the absence of a COVID-19 outbreak within the home, LTCHs residents face potential negative mental health consequences of lockdown. LTC residents have a high	• The study (January 2021) recommends that robust and evidence-based clinical information systems are essential to support the surveillance of mental health outcomes and evaluation of strategies to improve socialization during a public health emergency such as the COVID-19 pandemic. The interRAI LTCF assessment is a standardized instrument used to record clinical observations from a structured clinical interview, observations, and document review.[c] Assessments include

[b] LTCHs and long-term care facilities (LTCFs) are used interchangeably within this table based on the terminology used in the source documents.

[c] The homes included in the study began restricting visitors between March 12 and March 16, 2020. All group activities within the LTCHs were also halted in March 2020. Once lockdown began, recreation staff were redeployed to focus on keeping family connected with LTC residents. Strategies included window visits and video chats. To support these initiatives, the government of New Brunswick supplied LTCHs with one iPad per every 10 residents to connect with family members via video chat in April 2020. One of the homes also hired students to facilitate virtual calls and engage in one-on-one visits with residents. Between May 20 and June 15, 2020, the homes began in-person outdoor visits with

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		prevalence and increased baseline risk of developing mental health conditions including depression, delirium, and behavioural problems. Reduced social interaction associated with lockdowns during the COVID-19 pandemic could further increase the risk for worsening mental health outcomes. Stress among LTC staff could lead to stress among residents, increasing the risk for delirium, and behavioural problems. Isolation, lack of family contact, and lack of stimulation from social activities within the home could lead to boredom, loneliness, and depression.[2]	domains critical to the care of frail older persons, including health instability, function, falls, dementia, delirium, depression, pain, social engagement, quality of life (QoL), communication, and caregiver stress. The data from inteRAI can provide essential information to frontline staff to guide daily care and human resource planning and can describe the effect of strategies to prevent worsening conditions, such as mental health outcomes during lockdown. ○ InteRAI is an example of how clinical information systems can be used in a community of practice to examine changes in resident outcomes over time and evaluate strategies put in place to mitigate negative outcomes. In particular, the network of seven private, not-for-profit LTC homes in the study who did not experience COVID-19 outbreaks but were locked down for three months were able to mitigate the negative effects of social isolation on depression, delirium, and behavioural problems. Using depression, delirium, and an aggressive behaviour assessment embedded within the interRAI LTCF allows for the quantification of changes in these measures over time, including effects of COVID-19 policies such as lockdown, without requiring additional documentation or data collection. In addition, homes can use these routinely collected data to monitor residents' mood over time and evaluate the effect of home-level strategies (e.g., redeploying activity staff). Likewise, policy makers can use these data at a jurisdiction level to evaluate the effect of strategies (e.g., providing iPads). • The study recommends that deployment of strategies to improve LTC residents' social engagement may mitigate the negative consequences of lockdown, including mental health outcomes such as depression, delirium, and behavioural problems.[2]

family. Provincially, there were no COVID-19 cases in New Brunswick LTCHs between March and September 2020. Therefore, these homes provide evidence about the net impact of lockdowns where COVID-19 is not present in homes or in the surrounding communities.[2]

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Canada **Study** **Nursing Home**	• Physical isolation or quarantining in a LTC setting	• **Physical, Functional, Cognitive, and Mental Health:** According to a guidance document (October 2020) on supporting the re-opening of Canadian nursing homes, during the first few months of the COVID-19 pandemic in Canada, nursing homes implemented strict no-visitor policies to reduce the risk of introducing COVID-19 in these settings. As a result of these policies, many nursing home residents have sustained severe and potentially irreversible physical, functional, cognitive, and mental health declines.[5]	• The study recommended different strategies to support the health and wellbeing of residents in nursing homes: ○ Number of Allowable Visitors at One Time: ▪ *Outdoors*: Outdoor visits can include more than one visitor at a time, provided that physical distancing can be maintained. Additionally, family members from the same household and/or bubble should not have to physically distance from one another. ▪ *Indoors:* One visitor per resident in the home at a time.[5] ○ Allowable Locations of Visits and Access During an Outbreak: Outdoor visits should be prioritized, when possible and feasible, to minimize the risk of COVID-19 transmission and to maximize the number of possible visitors. When outdoor visits are not feasible for either the resident or the visitor (e.g., for cognitive, psychiatric or physical reasons), the home must provide an indoor alternative that provides ample open space for physical distancing and adequate ventilation.[5] ○ Allowable Access During a COVID-19 Outbreak: If the home goes into COVID-19 outbreak status, general visits may need to be temporarily suspended (if advised by the local public health authority), but if the outbreak does not involve the entire home, consideration should be given to suspending visits only on the floor or unit under outbreak. Virtual visits must be upscaled during suspensions of in-persons visits.[5] ○ Screening and Testing Requirements: Visitors must pass an active screening questionnaire (which may include an on-site temperature check) but there should be no requirement for COVID-19 testing for outdoor and physically distanced visits. If exceptional circumstances necessitate a visitor entering the resident's room, they should be subject to the same screening and testing requirements as family caregivers.[5]

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			○ IPC and PPE Requirements: Visitors must remain masked (cloth or surgical/procedure for outdoor visits and surgical/procedure for indoor visits) at all times and maintain at least two metres of physical distance from the resident they are visiting. Visitors should be encouraged to bring their own cloth masks for outdoor visits, but appearing without a mask should not be a barrier to visiting. Homes must maintain ample PPE supply to enable resident visits. Failure of visitors to comply with procedures could be grounds for a loss of visiting rights, which should be appealable.[5]
Canada **International Psychogeriatric Association** **LTCH**	• Physical isolation or quarantining in a LTC setting	• **Social Isolation:** An International Psychogeriatric commentary (October 2020) on the effect of COVID-19 on the mental health care of older people in Canada suggests that it is probable that social distancing will lead to less frequent contact by older adults with their family physicians, who are the frontline for treating mental health problems in Canada and the gatekeepers for most outpatient psychiatric referrals. As a result, more incident cases of mental disorder may go undetected and untreated. Social distancing may also lead to an increased sense of isolation and loneliness, which are risk factors for the development of depression and cognitive impairment.[11]	• The commentary (October 2020) suggests that the LTC sector needs innovative solutions to provide psychiatric care to residents and support for staff. LTCHs are typically understaffed, and many staff do not have the knowledge and skills to adequately manage psychiatric symptoms and problematic behaviours. In addition, some facilities have limited access to smoking areas, which creates a challenge in managing residents with chronic mental health conditions. LTCH rely on the resources and expertise of psychogeriatric outreach teams to provide guidance in managing residents with dementia, as well as older individuals with serious and persistent mental illness. In lieu of providing on-site support during the COVID-19 outbreak, psychogeriatric teams are exploring ways to provide impactful digital support. For example, digital access to behavioural support specialists who are on call and can provide rapid consultation. Tablets could be used by LTCH staff, as well as by family members to observe, support, and interact with residents who are in physical isolation because of infection, although the current challenges are availability of devices and uneven Wi-Fi connection.[11]
Canada	• Physical isolation or	• **Mental Health:** According to a Canadian Academy of Geriatric Psychiatry report (February 22, 2021) on mental health care in	• According to the report (February 22, 2021), staff training approaches are among the best supported interventions for

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Canadian Academy of Geriatric Psychiatry **LTCFs**	quarantining in a LTC setting	LTC during COVID-19, LTC residents describe their experience during the course of the pandemic as devastating, emotional, terror awakened, muzzled, trapped, broken-spirited, and boredom.[12]	addressing behavioural symptoms of dementia in LTC settings. Guidelines recommend that all LTC facilities provide staff with training in the assessment and management of common mental health disorders such as delirium and depression, management of neuropsychiatric symptoms, and responding to emergent mental health crises. These training programs require access to trainers (often associated with geriatric mental health programs) as well as resources to allow staff to attend these courses as part of their paid employment while ensuring an adequate number of staff are available to support the ongoing needs of LTC residents. Some LTC homes may have mental health champions or embedded mental health resources provided by the LTC facility or through partnerships with provincial mental health programs. Mental health care provided by LTC staff can be supplemented by regional outreach programs or telemedicine.[12]
Australia, Sydney **Commentary** **Residential Aged Care Facilities (RACF)**	• Physical isolation or quarantining in a LTC setting	• **Social Isolation:** According to a study (November 2020) on COVID-19 in Sydney nursing homes, the long period of quarantine was distressing for residents and relatives in nursing homes. Contact was facilitated by phone, video, text messaging, voicemail, or in-person contact with physical distancing from a balcony or behind a transparent barrier. **Physical and Mental Health:** The lack of physical contact, exercise, and fresh air impacted residents' mental and physical health. Some became depressed, withdrawn, or physically deconditioned.[10]	• This study (November 2020) highlights the importance of mobilization and resuming family contacts as soon as possible.[10]
France **Study** **Retirement Homes**	• Physical isolation or quarantining in a LTC setting	• **Mental Health:** This study (July 13, 2020) on high depression and anxiety in people with Alzheimer's disease living in retirement homes reported higher levels of depression and anxiety during than before the COVID-19 crisis. Some factors that contribute to poor mental health include: ○ Social Isolation: Retirement homes in France, as well as in	• This study (July 13, 2020) calls for clinical interventions to deal with the psychological consequences of this crisis. Ideally, psychological therapies (e.g., cognitive and behavioural therapy, mindfulness-based stress reduction, meditation) should be offered to residents at the end of the period of social distancing to help them recover.[3]

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		European and North American countries, are currently prohibiting all visitation. Non-essential activities and services are also being restricted, including social activities, such as communal dining. In some cases, residents are asked not to leave their rooms and, when in wards, to keep a safe distance from other residents to avoid contracting the virus. In addition, they have not been allowed to have physical contact with their family members and friends, even during sickness.[3] ○ Death: Social distancing measures have prevented residents of the same unit from saying goodbye to the deceased. ○ Care Dependency: The reduced physical contact with caregivers who, despite their efforts to provide the best care, have been dealing with an increased workload, shortages in equipment and supplies, and increased postmortem care.[3]	• Future training and education programs for caregivers should be offered on how to deal with the mental health consequences of similar crises.[3]
Europe **Latin America** **Systematic Review** **Care Homes**	• Physical isolation or quarantining in a LTC setting	• **Mental Health**: This rapid review (preprint) (March 20, 2021) on the effect of COVID-19 isolation measures on the cognition and mental health of people living with dementia shows evidence of worsening of cognition, neuropsychiatric symptoms, and level of function for activities of daily living in Europe and Latin America.[4] • **Medication Use:** The rapid review showed an increase in prescription of antipsychotics and benzodiazepines for the psychological symptoms.[4] • **Cognition:** This rapid review found a large proportion of people with dementia experiencing a decline in their cognitive abilities due to lockdown.[4] • **Social Isolation:** People with dementia in care homes are believed to have gone through the hardest version of COVID-19, both in term of mortality and effects of confinement, including decisions such as not being referred to hospitals and ban on visitors which, while made to protect the population, can be regarded conflicting with individual human right.[4]	• This review (March 20, 2021) makes the following calls for action: ○ Family caregivers and paid carers should be prioritized for vaccines so home care is not disrupted. Of particular importance is to offer vaccination to staff when they are working on shifts.[4] ○ The risk of infection is low outdoors, and the correct use of appropriate PPE can allow safe close physical contact. This knowledge should be used to restore routines, support, and therapeutic activities in the community for people with dementia.[4] ○ Care homes in many countries are progressing in the immunization of residents and workers but even in the cases where this is not happening, safe visits can and should be maintained.[4]

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Netherlands **Study** **Nursing Home**	• Physical isolation or quarantining in a LTC setting	• **Loneliness:** According to a study (July 2020) on allowing visitors back in the nursing home during the COVID-19 pandemic, restrictive measures impact residents and their wellbeing and pose dilemmas and challenges for staff. Despite technological innovations like video calls and creative solutions being tried (e.g., window visits, or separate containers using plexiglass outside the building), residents are socially isolated. Some residents have to be isolated within their own room because of COVID-19 infections in their unit. Prior research has indicated that loneliness and social isolation have negative consequences for residents' health and wellbeing.[7]	• No information identified.
Netherlands **Study** **LTCFs**	• Physical isolation or quarantining in a LTC setting	• **Social Isolation:** According to a study (November 2020) on the impact of COVID-19 measures on the wellbeing of older LTCF residents in the Netherlands, the Dutch government implemented a visitor ban in all LTCFs. In many instances, physical visits were replaced by social contact via telephone and video calls, or through windows. Many LTCFs closed social facilities and stopped daytime programs.[1] **Mental Health:** Although the LTCFs' policy prioritized safety, scarce attention was paid to residents' wellbeing and autonomy. Six to 10 weeks after implementing of the visitor ban, high levels of loneliness, depression, and a significant exacerbation in mood and behavioural problems were reported. Residents without cognitive impairment (CI) were reported to be the most affected. The implementation of the measures has reduced the incidence of COVID-19 infections and thus the number of deaths in LTCFs; however, a better balance between physical safety and wellbeing is necessary.[1]	• The study (November 2020) suggests that LTCFs should implement policies on allowing visitors and continuing daytime activities as much as possible in times of COVID-19. This should be done in conjunction with residents, family, and staff, prioritizing residents' wellbeing and autonomy again.[1]
US, Connecticut **Study**	• Physical isolation or quarantining in a LTC setting	• **Mental Health, Cognition, Weight Loss, and Urinary Incontinence:** This study (March 16, 2021) on the adverse effects of the COVID-19 pandemic on nursing home resident wellbeing shows that the pandemic had substantial impacts on	• The study (March 16, 2021) suggests that through targeted interventions, the negative impacts of social isolation can be mitigated.[6]

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Nursing Home		nursing home residents. On several measures—such as rates of depression, incidence of substantial unplanned weight loss, cognitive functioning, and incontinence—nursing home resident outcomes worsened corresponding to the time of the pandemic.[6] • **Social Isolation**: Isolation (i.e., reductions in direct care provision, policies that restrict visitors) contributes to the reductions in resident wellbeing.[6] • **Care Dependency**: There is a well-documented relationship between the level of staffing in nursing homes and the quality of care received by residents. Nursing homes have had difficulty maintaining sufficient staffing due to low wages and the demanding nature of the work. The COVID-19 outbreak may have exacerbated these challenges. The fear of the virus, negative media coverage of nursing homes, and focus on hospital staff and resources has compounded an already stressful situation for nursing home staff who have been overburdened given staff shortages and new responsibilities to address COVID-19 protocols. Additionally, limitations on visitors mean that family members and other unpaid caregivers, who normally provide important supplemental care to nursing home residents, have difficulty fulfilling that role.[6]	
US, **Florida** **Study** **LTCFs**	• Physical isolation or quarantining in a LTC setting	• **Loneliness:** A study (July 1, 2020) on loneliness and isolation in LTC and the COVID-19 pandemic, suggests that although prohibiting group activities will decrease the risk of spreading the COVID-19 infection in nursing homes, it significantly increases the isolation and resulting loneliness of residents. LTCFs prohibit visits from outside, including visits by family members. This is especially burdensome for residents with CI and dementia. Many family members of these residents visit often, sometimes every day, bring food, and help the residents with eating and drinking. If they cannot visit, they may be afraid that the resident will no longer recognize them.[8]	• The study suggests the following low-cost ideas to decrease loneliness in residents in nursing homes or assisted living communities: ○ Wearing a name tag that can easily be read helps to make a connection between the staff and residents.[8] ○ Ask family members of residents who can operate a personal computer or iPad to purchase one to help them stay connected.[8]

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US, **Florida** **Psychiatric Times** **LTCFs**	• Physical isolation or quarantining in a LTC setting	• **Social Isolation:** According to a Psychiatric Times commentary (Nov 11, 2020) on the impact of COVID-19 on mental health in LTC settings, LTC residents have been confined to their rooms without congregate dining, activities, and in-person family visits. They experience limited exercise, direct sunlight and fresh air, and a normal level of social interaction. At times, residents have had limited access to medical, mental health, and other therapeutic services.[9] • **Care Dependency:** Because the majority of residents are not tech-savvy or even tech-capable, they have been fully and passively reliant on the time and availability of staff to facilitate video chats with family. Patients may be traumatized by the news on the radio or TV, seeing other residents ill or dying, being ill themselves, and by experiencing the disruptions and losses brought on by COVID-19 spreading throughout the facility. Even under the best of circumstances, residents are often bored, lonely, anxious, sad, and confused.[9] • **QoL:** Communicating with residents can be limited by generational differences across residents and younger staff and family members, further complicating their ability to understand and cope with what is happening. These emotional disruptions can lead to new or recurrent mental health conditions, post-traumatic symptoms, and life-threatening states due to failure to thrive, especially in those who survived infection.[9]	• The commentary (Nov 11, 2020) suggests that rigorous infection control, including the screening and regular testing of all employees, along with proper and consistent use of PPE, can reduce the risk of residents being infected. Equally important are efforts to attend to the mental health of staff and residents.[9] • Recommendations to help reduce social isolation and improve engagement with resident include: o Staff becoming surrogate family members with frequent and more lengthy contacts, who wear photos and name tags on top of their PPE; o Regular video chats with family members facilitated by social work and/or therapeutic programming staff; o Regular telehealth visits provided by doctors and other therapists; o Treats and programming (e.g., music therapy) that can be carried out to the door, room, and bedside of the resident; o Drive-thru family visits to the facility using masks and social distancing; and o Activities brought to resident rooms via video and/or closed-circuit TV.[9]

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