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# The Impact of Public Health Restrictions in Residential Aged Care on Residents, Families, and Staff During COVID-19: Getting the Balance Right

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**ABSTRACT**

Outbreaks of COVID-19 in a small number of aged care facilities in Australia had devastating mortality ratios. Strict infection control measures were implemented with little time to adapt. This study explored the views and experiences of residents, families, and care providers about the preparation for COVID-19 and identified areas for improvement. Twenty-one individual interviews were conducted. Using interpretative phenomenological analysis, we found rapid changes to visiting and activities, with physical and emotional impact. Some participants coped using personal resources. Family and residents valued the empathy and quality care provided, despite the overburdened workforce. Good leadership supported implementation of public health advice, but the severity of measures should be proportionate to local risk. Better pandemic planning that includes clear responsibilities, training, and evaluation is important. Consultation with residents, family, and health workers throughout a pandemic will help identify those most at risk of social isolation and physical decline and develop strategies to minimize their impact. The rights and welfare of residents must be respected at all times.

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## Introduction

The first Australian case of COVID-19 was confirmed in late January 2020. By April 29th, 2021 there were 29,779 cases with 910 deaths. Most cases were in those aged 20–39 years, but most deaths (694) occurred in those aged ≥ 80 years with females accounting for 57.0% (396). As of April 29th,

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nationally, there have been 2051 cumulative cases in Residential Aged Care Facilities (RACFs) and 685 deaths (Australian Government Department of Health, 2021).

COVID-19 is a highly contagious virus with poor outcomes strongly associated with age. Residents in RACFs are already vulnerable due to age and physical and cognitive co-morbidities (Levine et al., 2020). Outbreaks of COVID-19 in a small number of RACFs in Sydney and Melbourne had devastating mortality ratios. In these settings, strict infection control measures were implemented swiftly with little time for residents, families, or staff to adapt. A human biosecurity emergency period was declared under the Biosecurity Act 2015 on March, 17th 2020 and remains in force. This ensures the Australian Government has the power to take necessary measures to prevent and control COVID-19 (Parliment of Australia, 2020). The Public Health Act (2010) allows specific measures to be implemented by state governments (NSW Government). Changes include "lockdowns" with restrictions on visiting, isolation and quarantine measures, social distancing, use of Personal Protective Equipment (PPE), and other infection control measures.

RACF restrictions at the time of the study were guided by State Governments through Public Health Orders and recommendations from aged care bodies and infection control experts (Australian Government, 2021; Australian Government Department of Health, 2020; Barker & Hewitt, 2020). Restrictions included limiting visitors within facilities to 2 persons for care and support, preventing entrance visitors or staff who attended a location in the last 14 days where there had been a COVID case, for staff this also included having to return a negative PCR test prior to returning to work. RACFs located in areas of increased COVID-19 transmission only permitted entry to visitors who provided essential caring duties. Strict infection control measures were in place for all facilities including temperature and COVID −19 symptoms screening on entry to the facility, mandatory COVID-19 specific infection control training for staff, and mandatory influenza vaccination and wearing of PPE including face masks for all visitors and staff entering the facility. All RACFs were required to have a COVID 19 outbreak management plan.

Anecdotal reports of residents' loss of physical conditioning, loss of appetite and a reduced desire to socialize or move about outside their room have emerged, while families have reported experiencing worry, distress, and frustration. Health staff who often have little formal training in infection control or use of PPE may have experienced fear, stress and exhaustion as responsibilities increased and health staff numbers decreased (Gilbert, 2020; Gilbert & Lilly, 2020b; Levine et al., 2020).

This study aimed to gain deeper understanding of the experiences and views of residents, families, and care providers about the preparation for COVID-19 in RACFs in the Hunter New England Local Health District (HNELHD) in New South Wales (NSW), Australia and to identify areas where improvements could be made in preparing for future outbreaks.

## Methods

### Approach

Qualitative methodology was used with a phenomenological approach to explore the lived experiences of participants facing the phenomenon that is COVID-19 (changes/policies/restrictions imposed in aged care facilities; Byrne, 2001). Each participant, with their own, subjective "reality" helped us to understand how preparation for cases impacted on them emotionally, practically, and in other ways (Byrne, 2001; Palmer et al., 2010).

### Setting and selection criteria

The setting was RACFs in the HNELHD. We invited RACFs from a list of 38 facilities that had participated in a previous telephone survey about preparation for a first COVID-19 case. Selected RACFs were from both rural and urban areas, owned by a range of organizations including private and government, and with both large and small numbers of staff and residents (Tolley et al., 2016). For ethical reasons, RACFs experiencing an outbreak of COVID-19 (defined as one case) were not invited to participate as our study focused on the preparation phase. Also not included were residents with cognitive impairment or those receiving palliative care, nor grieving family members who had experienced the recent loss of a family member. Family members of residents with cognitive impairment were included.

### Recruitment

We used maximum variation sampling to select a wide representation of views and experiences relevant to our study aim. Potential participants included residents, family members and health staff who provide direct care to residents. Managers from the RACFs were provided an information statement for their organizations and asked to consent on behalf of their facility. Managers promoted the study sending Participant Information Statements to health staff and family members using their usual communication channels (e-mail, newsletters, and team meetings). Managers were asked to identity residents who might be interested and

able to participate and to provide them with an information statement and consent form. Researchers were available to answer any questions that potential participants had about the study.

### Data collection

Individual interviews were used for all data collection. Due to COVID's visiting restrictions under Public Health Orders and physical distancing requirements, interviews were conducted using telephone or online platforms including Zoom or Skype. Individual interviews allowed researchers to explore participants thoughts and feelings more deeply than might have been possible in focus groups with people unknown to them, where they may have been more guarded. In order to facilitate an effective interview with residents, we invited a health staff member who had a close relationship with the resident to assist in the use of telephone or online technology, ensuring that they had heard and understood the questions and to clarify any misunderstanding the researcher might have. The staff member assisting the resident was provided with a confidentiality agreement. Verbal consent was recorded prior to commencement of the interview. An A$25 (1A$ = 0.7US$) gift card was provided to residents and family members as a token of appreciation for their time. Interviews with staff members were conducted during work time.

The interviews were semi-structured. The question guide was simple with open ended questions exploring participants' experiences of changes in their usual routines related to COVID-19 and what had or had not worked well, and what could have been done differently. Participants were asked about how they felt during these times of change and how they had coped with emotions and challenges. The process was iterative, allowing new lines of inquiry to be followed in subsequent interviews (Tolley et al., 2016). This format allowed participants and researchers to follow a range of experiences and topics. Interviewing continued with family members until saturation occurred and no new ideas were expressed. Interviewing included all residents and staff that agreed to participate.

Interviewers had a range of background experience that provided both "insider" and "outsider" perspectives. ST has a background in nursing, public health, and qualitative research. RL is a public health nurse with expertise in communicable diseases and outbreak management. JH is a nurse with experience in RACF management. KB has experience in social science, public health, and qualitative research.

### Data analysis

Interviews were digitally recorded and transcribed verbatim for analysis. Researchers used interpretative phenomenological analysis to examine the personal lived experience of each participant before developing overarching study themes (Eatough & Smith, 2008). Themes were both pragmatic and descriptive of feelings and emotions, the former being useful to inform change to policy and planning, and the latter giving voice to those seldom heard. For each transcript, ideas, concepts, words, or phrases were grouped into broader categories by an individual researcher. For dependability, these were then compared with findings from at least one other researcher and consensus was reached. From these categories themes were developed, which captured or defined the key messages relevant to the study aims. This involved several "back and forth" discussions and refinement of the themes before agreement was reached. To strengthen credibility, a summary of the study results was provided to all participants, who were offered the opportunity to provide additional comments. Two family members replied with support for the findings and no new intelligence was contributed.

Ethics approval for the study was obtained from the University of Newcastle's Human Research Ethics Committee (H-2020-0208).

## Results

Interviews were conducted between September and December 2020. During that period, across Australia, daily case numbers remained less than 25 and total confirmed deaths were less than 250 (Our World Data, 2021). COVID-19 vaccines were not yet available. Four RACFs took part in the study with 10 family members, 6 residents, and 5 health care providers participating for a total of 21 individual interviews. Participating family and residents were not related. Five themes emerged: 1) The public health response to COVID-19 brought rapid changes to the usual visiting, resident outings, and recreational activities in RACFs; ii) Changes in facility functioning had varying physical and emotional impacts on residents, family and staff; iii) Ability to draw on a range of resources has helped some family and staff to cope with the changing context; iv) Family and residents appreciated the empathy and quality care provided despite the overburdened workforce; v) Good leadership and management supported implementation of public health advice but the severity of measures should be proportionate to local risk. These are discussed below with selected quotes to demonstrate credibility. A summary of what worked well, not so well, and what could be improved is provided at the end of the results section (Figure 1).

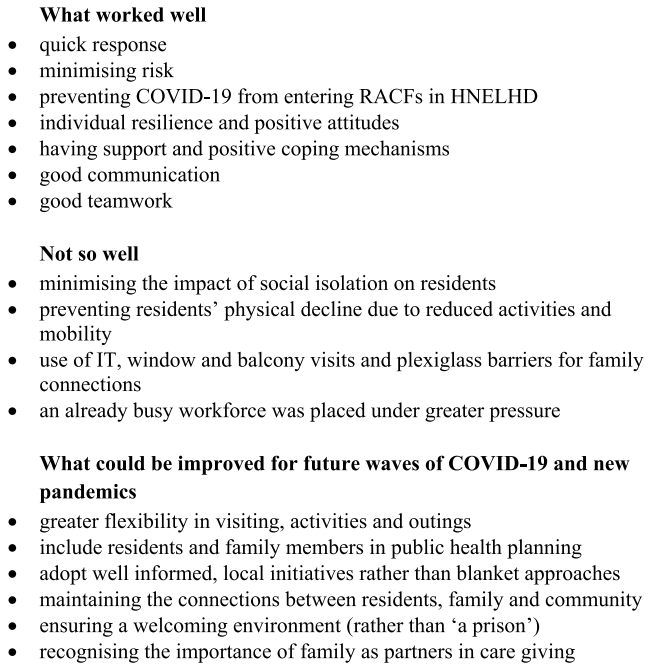


**Figure 1.** Summary of participant views about what worked well, not so well, and where improvements to pandemic preparedness could be made.

### *The public health response to COVID-19 brought rapid changes to the usual visiting, resident outings and recreational activities in RACFs*

All family members described the rapid changes to visiting rules at RACFs. These changes included who could or could not visit, when they could visit, if at all, and how visits were organized. Initially visits were restricted to adult family members who had been vaccinated against influenza. Young children and babies were not permitted to visit. Visits were generally limited to week-days for 2-hour periods in the morning and afternoon. Visitors were often restricted to the resident's room and were not free to move around and visit other residents. Family members from declared COVID-19 "hotspots" were not permitted to visit.

*Having the facility shut over both days of the weekend means you really do exclude a lot of people from being able to go. (Family)*

*So it's a long way just to see her for two hours. I understand that they have to do this but it just makes it difficult for us because we're such a long way away. (Family)*

Family members spoke about the cancellation of activities within the facilities and outings into the community. They reported changes to where you could sit to eat, changes to group activities, and cancellation of regular bus trips. Family were not allowed to take residents out for appointments, meals, or shopping; to their own home; or anywhere else. Some mentioned

the lack of access to hair dressing and that this was of significant concern to residents who relied on that service. Over time these restrictions eased and families were appreciative of the greater freedoms. Residents and staff, on the other hand, reported very little change in activities, apart from the need to maintain a social distance, increase handwashing, and use PPE.

*A little bus used to come around to her retirement village* [RACF] *where she would then hop on a bus and go to another retirement village and participate in all the activities over there. Of course, COVID stopped that. So then she ended up, as she said, quote, I'm just sitting in my room looking out the window, I've got nothing to do. (Family)*

*I don't think there's been too many disruptions to me. Everything's happening and we've got lots of help. (Resident)*

*We've maintained group activities here. We maintain it as a family environment, particularly when lockdown was on, so that they all still had that contact with each other, which we felt was really important for them to maintain their mental health, particularly if they couldn't see their family. (Staff)*

Families and staff discussed several new ways introduced to help families stay connected. These included use of iPads to connect using online platforms including Zoom and Skype. Other methods included window visits, veranda visits, visiting between plexiglass, using photo sharing apps and an increase in use of landline telephones. Some family members reported varying levels of success with these new technologies, saying it was new and interesting at the beginning but then "*the novelty wore off*" and then *"mum just wanted to meet face to face."* Poor hearing and vision and cognitive impairment also made it difficult to communicate using these new methods.

*It's new to everyone, not many have ever seen a tablet before . . . I thought it would be quite hard for them to understand, but 99% of them have just been over the moon with it. (Staff)*

*You could go and have an interview with mum and you would be outside the building and they were at a window inside the building. I never participated in any of those because mum was deaf so you're yelling through a window at somebody on the other side who couldn't hear you and that was stressful for her and for my sister. (Family)*

*I think they would have to rule out in future, any visits from a veranda. That is just the cruelest kind of situation. So I think that anything in the future, that would have to be avoided. (Family)*

*It was fully Perspex from wall to wall. That was challenging as well, because you still had to speak quite loudly to the residents to get conversation. Dad couldn't understand what that was about, and you could see that he was trying to kick it to get it out of the way, so from a dementia perspective, that was difficult for him as well, to make sense of this thing between him and us. (Family)*

There was a positive side as one resident connected with a friend she hadn't seen for a long time.

*Actually, something happened with that that was good for me too. Because I use my iPad to be on that choir* [one of my friends] *got in touch with me and I saw her. So she saw me and I could see her. It was wonderful. It was absolutely fabulous. (Resident)*

### *Changes in facility functioning had varying physical and emotional impacts on residents, family, and staff*

Residents reported few impacts on themselves. Most were pragmatic and accepting of the situation, saying, "*I've been going alright.*" They did report missing family and friends and that they had missed important family events like weddings and birthdays. Some residents expressed concern for staff who were stressed and busy. Some felt a responsibility to protect family and others from the virus.

*I don't think there's been too many disruptions to me. Everything's happening and we've got lots of help. (Resident)*

Family members reported important changes in their mother or father's wellbeing that they attributed to isolation; limited contact with family, staff, and other residents; and a lack of mental stimulation. Some reported their mothers being lonely, sad, crying, annoyed, and even frightened as they did not understand why their social connections were disrupted. Others observed a worsening of depression and anxiety and a withdrawing, no longer reading or sketching or tending to their plants, "*it was like she didn't see them.*"

*Mum hadn't – didn't and still doesn't really understand what coronavirus is all about. So for her, she saw it as a very – like a prison, basically and back to the days of war and being told what to do and what she can't do. (Family)*

*Well, I think it has affected her. We went to leave the other day and she didn't want us to leave. . . . she's sort of hanging on and hanging on. "I don't want you to go" [cries]. That's very unlike my mum. She's a very private person. (Family)*

*When they really confined to her room and even Mum said, if she doesn't see people, like see her own family, she'd rather be dead. Yeah, well that's really sad. (Family)*

Family also reported physical decline in residents due to less exercise, reduced mobility, and cognitive decline, including worsening dementia. Some speculated that those with cognitive impairment or who were more dependent may have had a worse experience.

*I have noticed more of a cognitive decline. I've also noticed a physical decline, often, in her room, she was just walking using her four-pronged walking stick to get around. She is now using the walking frame consistently. (Family)*

*Mum was a very active person. Walked and walked and walked a lot. Now it's very sedentary there. She's getting a lot of fluid and . . . sore legs and things.*

The impact of changes to visiting, activities and outings on many family members was significant. Some felt excluded from their role as a partner in caregiving and worried their mother might be thinking, "*well they haven't been around for me for a while. Why? Why?*" They were no longer able to detect early health changes, things were getting lost, laundry not taken home, and clothes were not changed for the new season. Some family members felt "*lockdown was like a prison*" which impacted on them emotionally. One person commented the lack of windows in their mum's room made it difficult for her to know the time of day. Some became very teary during interviews. It was difficult to plan visits for those family members who lived far away and this added a burden on those living nearby, disrupting their usual family life.

*We felt that we had a bigger role to play in mum's care. We're also aware that we've probably spent more time there than a lot of the other residents would have had from their families because we did see it as actually that joint caring. (Family)*

*There was nearly five months that I was not able to go into [RACF] to see Mum and Dad . . . .we're so close as a family, that was tough on me. (Family)*

Some staff members reported how difficult it was for their small community, where everyone is treated like family. Some reported an increased workload, having to cope with daily changes, new rules, and wearing masks all day. Staff reported stress, worry, and a negative impact on both their professional and personal lives. One person had considered resigning. At the same time, most staff felt the changes had a limited impact on residents and that "*everyone adapted*" and "*was not overly anxious about it.*"

*We had one lady who was really, had to wait, I think it was six or eight weeks before she could see her first great grandchild. So things like that . . . affected the town a lot, people not being able to visit . . .. . . because they're just so used to coming up and saying hello and being a close-knit community. (Staff)*

*A lot of them were super happy to think they were in the safest place they could be. That the virus is outside, and they're inside. They still got the care they needed, the doctor when they needed to be seen, they've got nurses on board, all their meals, they've got the care and support, the activities. (Staff)*

*Yeah, so I have had, in the last six months probably the roughest time I was coming home so frazzled and upset. It's not pleasant when you go home, and you're cranky, and you feel unappreciated. (Staff)*

*So things got a bit confusing, because it did come very quickly and changes did happen every day . . . so handover was a bit different at times too because they would actually have to tell us now this has changed, people can't come to visit, you have to wear a mask for this, you've got to do – you can't touch that now and things like that. (Staff)*

### *Ability to draw on a range of resources has helped some family and staff to cope with the changing context*

Family members reported using a variety of positive coping mechanisms to navigate their way through the changes to visiting, activities and outings, and the impact this had on them and their loved ones. These included seeking support from their partners, siblings, and friends, having a supportive workplace that understood the need for family to visit RACFs during business hours, relaxation, and using distractions or *"turning off during the day"* and *"trying not to think about it."* Many felt that it was easier to cope because they understood the rationale behind the changes, *"for keeping everyone safe from the virus,"* and felt comfort in knowing they were not the only ones experiencing challenges. A few family members mentioned their personal values and resilience that helped them adapt.

*I just sit out in the paddock for a while and just watch the world go by. That's – yeah, that's how I cope. (Family)*

*I don't see it as a permanent thing; I see it as temporary due to COVID. (Family)*

*I think you just have to cope really. I mean I'm really fortunate because I'm enjoying my sport, I've got a close relationship with my hubby and my kids.(Family)*

Staff members also mentioned being adaptable and resilient, and that good teamwork and good communication helped them cope with the changes. Some noted that *"over time things got easier"* and that *"time was a big thing"* in helping them adapt to the changes COVID-19 brought. Some focused on the positives, seeing that they were lucky to be *"spared from COVID-19"* in their community. One staff member in a small, rural community commented that *"everyone looks after everyone."*

*We do talk a lot together. On our breaks we have safety huddles and little meetings between each other to see what's working well and what's happening and what we can do to make things better. (Staff)*

*We're a very good team here. We reminded each other. You know "don't forget to put your mask on," "don't forget that this person has to be this far away." (Staff)*

*Yes, I've learnt that you just take it as it comes. Enjoy the day, do what you can, make sure everyone's safe and happy and hopefully your job's done right. But I suppose we're very lucky, we're in a small, little country hospital. We haven't had COVID here. (Staff)*

Residents in our study did not mention any particular ways of coping or resources that they drew on but did say they accepted the changes and that "*You just accept it. You do what you have to do."* One took more time to appreciate nature and her surroundings.

*Because I'm getting older too I am enjoying more things that are more natural, the flowers, everything. I can see more things in a different light. I'm appreciating things more. I mean I can hear the birds outside. (Resident)*

*What will be will be. I don't worry too much about things. I had a stroke doing that.*

*No, I think everything's fine. I'm quite content with where I am and what is happening. (Resident)*

*Most of our people [residents] have lived through a war, or more, and so talking about how tough those times were and how resilient they've been, and we know they have that resilience. We talk about things like that. (Staff)*

### *Family and residents appreciated the empathy and quality care provided despite the overburdened workforce*

Residents said they did not like to see the staff stressed and exhausted. One resident noticed the staff turnover, with more young and inexperienced staff commencing at her RACF. One resident felt *"the standard of staff here is excellent"* and others were also very appreciative of the level of care they received.

*I just think the nurses and that are very good here and they look after us with that, they wear masks all the time, which is pretty good. (Resident)*

*But sometimes they just don't have enough people and – well, it stresses me because I see them. Now, I can't do anything about that, I wouldn't imagine. (Resident)*

*We've got a lot of young new people coming in that they're too young to be looking after older people I think- a lot of people here that are really ill and need a lot of looking after and I don't think the younger girls can do it just yet. (Resident)*

Families frequently referred to the good care their parents received. Many spoke highly of staff, including carers, cooks, and cleaners, especially those who knew their mother or father well, and described them as caring, providing individual care, empathic, and going out of their way to help. Some family members observed that carers worked hard to provide individualized care even though they were busy. A small number spoke of some staff for whom it was *"just a job"* or who were not empathetic.

*I think the carers do bend over backwards . . . from what I can see, they are genuinely caring. Trying to help Mum in as many ways as they possibly can, yep. (Family)*

*One of the carers actually offered to take Mum to one of their preferred hairdressers. I mean, I didn't ask them to do that. They did that . . . they could have said to me, can you take her? We're all too busy. But they didn't. (Family)*

Families also expressed concern about staff shortages, turnover, and workload. Many observed that staff were very busy, *"really loaded quite heavily,"* with less time to spend with those who needed less help or to engage those who were isolated or withdrawn. Some family members were, at times, reluctant to ask for additional help because they didn't want to overburden staff who were already stressed and exhausted. Family members noted that new staff didn't know the residents well and were slower to pick up on problems with a disruption to continuity of care. One noted her mum's room *"looks a bit dirty,"* compared to pre COVID-19 times.

*She has actually put on a lot of weight. She has gone up two dress sizes. But it was mostly swelling. She's carrying a lot of extra fluid. She is very uncomfortable and got very sore knees. Now she is two shoe sizes bigger. That's not her feet. They went oh, really? Then they went and had a good look. Sure enough, yes she has put on a lot of weight. It's fluid. (Family)*

*I can't keep up with the new staff that are coming in and I visit every day. So let alone my dear old mum at 90 trying to build that personal relationship and a trust that this person is going to come and shower me.* (Family)

Some felt that not enough staff were recruited to address the social isolation and to have time to *"simply sit and be with residents"* or *"share a cuppa."* This was not seen as productive. Some family members thought more training for staff would be helpful, in the areas of self-care and how to demonstrate empathy to residents and families. Some suggested use of more volunteers to help or having a *"go to person"* who could be responsible for a group of residents, who knew them well and could advocate for them.

*One of the recommendations I would like to see that – is somewhere in the budget to employ somebody who can just go and sit with a resident for half an hour. Now, with mum that may not be half an hour of interaction verbally but it would be half an hour of mum knowing that somebody else is in the room with her. So you don't have to engage in conversation with somebody to feel connected. You can share emotions. You can share the physical space. (Family)*

*Unless you're actually seen to be producing something or pushing somebody in a wheelchair or working at a computer you're not productive. (Family)*

*If there was one person who was like mum's advocate, who knew their routines, knew who their family were. I would have that person to ring to ask questions. Because when I've rung in to ask about mum, I'm asking different nurses, different staff and chasing around because it's not the same people on. (Family)*

Staff commented on the increased workload. Despite some workplaces having extra staff ready or available, there was just not enough. Unplanned changes in workload, for example, more phone calls from family on the

weekends or needing to perform additional entertainment roles, placed further pressure on staffing levels. One staff member reported a lack of support when she had to stay home sick or travel in the rural area for COVID-19 testing.

*The local school would come in. We would have, just lots of musical stuff. All of those sort of things, and they're obviously all gone. That's meant that I'm now their entertainment, but I still have to do everything I did before, so there's obviously a bigger workload. (Staff)*

### *Good leadership and management supported implementation of public health advice but the severity of measures should be proportionate to local risk*

Many staff and family members supported the public health measures put in place to reduce risk and protect vulnerable residents from a new and unknown virus. Many appreciated the infection control measures including use of PPE, screening, availability of hand sanitizers, physical distancing, use of reminders, and modeling by staff.

*Well initially I think it was really good that they did lock everyone down for that initially scary week when it seemed like we were going to boom with the infections. I think it was great to lockdown. (Staff)*

*They have worked very hard in getting a specific isolation ward up and running. I know that Dad has been put over there because he had a sniffly nose. So while that was hard for Dad, with dementia, at least they were very proactive in utilizing that area. (Family)*

*I had a high level of confidence from day one that infection wouldn't get into the nursing home and my mum would be looked after. So, yeah like some minor inconvenience but versus death. (Family)*

Some family members felt that the blanket approach or "one size fits all" may not have been required, especially in rural areas where there were no known cases or apparent transmission. They felt greater flexibility about visiting, activities and outings could have been introduced earlier, helping residents stay connected with their family and community and thus counteracting the negative impacts of changes.

*I just can't understand now why she can't still go out because the staff can go in and out- they can go home to their families and they may bring it back in it – in tomorrow. But Mum's not allowed to mix with other people and she's not allowed more than two people. (Family)*

*She's [*family member*] not even allowed to go up to that facility and have Christmas lunch with [*her father*] which I think is absolutely wicked. Her visiting hours are still 10am until 12 noon or 2pm until 4pm. (Family)*

Both family members and staff recognized the value of good leadership and management. This included having a plan in place, supportive teamwork, and creating the new role of Connections Coordinator to help manage the visiting

and use of Information Technology (IT). Some felt the preparation could have been better and that the signage outside one facility, with chains, locks, and big Stop and Do Not Enter signs could have been *"less prison like."*

*The CEO I suppose has done a really good job of putting a team of people together who can prepare strategies so that the infection doesn't get into the nursing home. I suppose with all the problems that mum has at least the COVID did not get into the nursing home. That was through the strength and leadership of the team over there and I have for praise them. But it has had its impact. (Family)*

*They've run drills on what happens if we have an outbreak, and they've practiced like you do a fire drill. (Family)*

*Yes we did have training. Online training, as well as face-to-face training and things like that. (Staff)*

*They didn't actually have a COVID-19 plan in place until a couple of weeks ago, which I found a little strange. (Family)*

Family and staff spoke about the importance of various forms of communication used by RACFs to keep residents, families, and staff up to date with COVID-19 related changes. This helped reinforce the rationale for sudden changes to visiting, activities and outings and reduce anxiety. Newsletters, e-mails, SMS, and printed material were used. The printed material was helpful for some staff who were too busy to read e-mails. Some participants thought communication with residents could be improved while acknowledging it was difficult for residents with memory or cognitive challenges.

*Our manager was really good and ended up printing stuff out so every morning we'd have a new printout of what the actual restrictions were for the day and what we could and can't do and all that sort of thing. That worked well. (Staff)*

*We'd receive it by e-mail and there's days when you just don't get to check your e-mails. There's just no time, and if I'm away I don't check mine at home either. (Staff)*

*I know that [manager] and the staff have worked fairly well with residents to try and help them understand, but it's a difficult time when you've got residents that are unwell, residents that are not able to mentally work through the stuff. (Family)*

*I think that the biggest things would be better access to family, better access to activities to keep them more occupied, and better communication to the residents themselves I think. They're the three things I would pick as being – that didn't go so well. (Family)*

## Discussion

The public health response to COVID-19 in Australia has been swift and comprehensive. The number of cases, hospitalizations, and deaths have been relatively low compared to other countries. Restrictions were imposed on

RACFs to protect older adults, who were deemed at greatest risk and most vulnerable. Australia did experience a small number of COVID-19 outbreaks in RACFs, where the severity of the virus and the swiftness of its transmission in these setting confirmed the international experience. Once COVID-19 entered an RACF, it was very difficult to contain. For these reasons, the restrictions on visiting, activities and outings were deemed necessary, albeit harsh.

Our study found widespread support for those restrictions that kept the virus out of RACFs and kept everybody safe. Others have described the restrictions as extreme and labeled them punishing and cruel with their physical and psychological implications (McGrath, 2020). As time progressed, some respondents raised questions about the necessity of prolonged restrictions in areas where there was no apparent transmission of the virus, such as rural areas where there were no known active cases. As the impact on residents and families was significant, both the severity and protraction of the response came into question and a more tailored or localized response was suggested.

Older people are vulnerable to the effects of social isolation and loneliness (Dassieu & Sourial, 2021). Adverse effects include an increased prevalence of vascular and neurological disease, premature mortality, cognitive decline including progression of Alzheimer's disease, emotional distress, anxiety, and depression (Plagg et al., 2020). Other physical effects include fall-related injuries, pressure ulcers, infections, and delirium (Dhama et al., 2020). Social isolation in older adults has been described as a "serious public health concern" due to its impact on physical and mental health. Those who are already isolated and lonely may be placed at even greater risk due to COVID-19 restrictions (Armitage & Nellums, 2020). Human Rights Watch interviewed families of residents with dementia from RACFs in NSW and Victoria who described the impact of restricted visiting during COVID-19 on their loved ones (Human Rights Watch, 2020). Our results resonate with their report, submitted to the Australian Royal Commission into Aged Care, which found a decline in resident's physical, social, and emotional wellbeing including loss of appetite, weight loss, and reduced mobility. In the report, some families described the distress experienced by residents and their families as those with dementia tried to open doors and get out during window or gate visits. Residents could not understand why family were no longer visiting face-to-face. This was heart breaking and described as cruel (Human Rights Watch, 2020). Visiting through the use of technology was not considered as effective and families said their loved ones needed touch, face to face connection, and smiles. Without this, many withdrew. The submission included the recommendations that RACFs must recognize the risk of social isolation and eliminate visitor bans (Human Rights Watch, 2020). Training staff in equity-oriented care and allocation of resources to those most likely to experience

isolation should form part of preparedness planning (Dassieu & Sourial, 2021). Similar sentiments were expressed in our study with some family members concerned that residents were at greater risk of isolation and its effects and that staff training in demonstrating empathy would be valuable.

The workforce in RACFs struggled with inadequate staffing levels and skill mix long before COVID-19. Many residents are dependent on care provided by family members to assist with meals, personal care, and social and emotional wellbeing. Without that support resulting from COVID-19 restrictions, families reported physical, social, and emotional deterioration (Verbeek et al., 2020). Despite increasingly complex heath care needs, there has been a steady erosion of workforce standards and defined levels of staffing (Gaetano Pagone QC & Lynelle Briggs AO). Training opportunities for care workers are inadequate and Registered Nurses are burdened with administrative tasks. Nurse Practitioners are restricted from practicing in the sector by barriers in the Medicare Benefits Schedule (Wise, 2020). Casualization and subcontracting of the workforce with poor job quality, low pay, and a poor public image means the sector cannot recruit and retain the professional staff needed to meet the complex needs of residents. In 2019 more than half RACF residents (57.6%) were found to be living in facilities with unacceptable staffing levels (Wise, 2020). The Australian Royal Commission to Aged Care has exposed policy failure as governments have downplayed the increasingly complex physical and behavioral needs of older people, while allowing inadequate staffing levels to prevail. The commission found aged care services are largely task based with standardized processes focused on meeting the physical or medical needs of residents. The current model does not recognize the importance of meeting the social and emotional needs of residents. Many staff and facilities do strive to deliver the best care but are simply overwhelmed by inadequate funding and lack of professional support and training (Gaetano Pagone QC & Lynelle Briggs AO). Some family members in our study reflected on this model and wished someone was available to simply sit and spend time with their mum, sharing a space and feeling connected.

Ageism is pervasive in our society including public policies (Previtali et al., 2020). Before COVID-19, older adults were often marginalized, socially isolated, and segregated in RACFs. Paternalistic attitudes mean that "we know what's best" for residents and how they should be protected. Our most vulnerable were poorly consulted, if at all, in developing the public health response to COVID-19 in RACFs (McGrath, 2020) and so there was a loss of agency and a breach of peoples' Human Rights (D'cruz & Banerjee, 2020; McGrath, 2020; Previtali et al., 2020). This response has been utilitarian in its aim to prevent the virus from entering facilities and to protect older adults from severe illness and death. The Grattan Institute, an independent institute focusing on Australian public policy, takes a rights-based approach to reform in the aged care sector (Duckett et al., 2020). With the focus on safety over

autonomy many residents were virtually imprisoned in their own rooms with increased depression, anxiety, suicidal risk, and a sense of hopelessness. Their report states "individual rights to autonomy and freedom of movement should not be set aside in a crisis." Rights include choice and control in pursuit of their goals, planning and delivery of support and services, and the recognition that families and carers have a crucial role in the lives of older adults (Duckett et al., 2020).

Our results found widespread support for public health measures to reduce the risk of COVID-19 entering RACFs. As time passed, it became apparent that this came at a cost and the issue of getting the right balance emerged. This poses a challenge for public health policy makers as a more nuanced approach is called for. There have been a number of reviews following large outbreaks in RACFs in NSW and Victoria (Gilbert, 2020; Gilbert & Lilly, 2020b). Inadequacies were found in emergency planning and preparedness, infection prevention and control capacity and capability, leadership, surge workforce planning, and in health department communication (Gilbert & Lilly, 2020a). Drawing on international experience, there has been a serious lack of pandemic preparation in this sector and a lack of knowledge about the likely physical and psychological effects of isolation on older people (Dhama et al., 2020). Residents and family members have generally been bypassed in the development of strategies and policies that could have built in greater flexibility, adopting a careful local risk-based approach, and respected the rights and dignity of residents while observing infection control measures (McGrath, 2020). While it is important to use all the public health tools available to minimize risk of infection and protect older residents, a commitment to getting the balance right would seek to ensure social integration and active connection to family and community are maintained. These connections may help build resilience and be protective against the effects of isolation (D'cruz & Banerjee, 2020). Adequate and appropriate emotional stimulation and physical exercise should form part of that balance (Dhama et al., 2020), with the aim of preventing unintended harm if restrictions become prolonged (Roy et al., 2020). Those most vulnerable to the effects of isolation, including those already experiencing loneliness and depression, must be identified early with extra support tailored to reduce the effects of distancing and separation from family and friends. It is imperative to conduct a review or evaluation after restrictions have been lifted to provide evidence that will allow better preparation for the next pandemic or pandemic wave and mitigate unintended consequences (Roy et al., 2020).

### *Limitations*

This study has some limitations. It was difficult to recruit RACFs that may be risk averse and cautious about participating in anything that may produce negative findings. They were also exceedingly busy with staff shortages and

adjusting to frequent guideline changes. It was also difficult to recruit residents and staff as we relied on facility manager's assistance. After two reminders, no further attempts were made. There may thus be some selection bias toward more engaged facilities. Family members who had more negative experiences may have been more motivated to participate while residents who were more physically and mentally able to participate were recruited. As such, we have likely not heard the full range of views. The voices of residents from RACFs are seldom heard and we feel even the small number from our study adds important views to the literature. It was not possible to ascertain if the physical, emotional, or psychological changes were due to COVID-19 or other causes. We did seek to clarify this during interviews and incorporated those responses in our analysis. Some residents reported that they may have forgotten some of the impact of COVID-19 restrictions as several months had passed between the initial changes and our interview. As with all qualitative methodology, our results represent the views of participating individuals and RACFs and are not transferable. However, we believe many of the concepts may be more broadly applicable.

## Conclusion

The COVID-19 pandemic brought dramatic changes to the routines within RACFs with prolonged restrictions to visiting, activities and outings, and a disruption to the social connections between residents, families, and communities. The impact has been significant. Better pandemic preparation and inclusion of residents and family members in the development of public health strategies can help minimize the physical, emotional, and psychological consequences. It is important to recognize the prevalence of ageism and paternalism in our health and aged care services and understand how these can easily quash the rights of older people. Our study results will be shared widely with community, health, and industry partners to help formulate inclusive strategies for further waves of COVID-19 and future pandemics.

## Key points

- A pandemic plan including responsibilities, training and simulation is imperative
- Residents at risk of isolation and physical decline should be quickly identified
- Pandemic plans should be flexible and responsive to local epidemiology
- Consultation with residents and family members is required throughout a pandemic
- Residents' rights and welfare should be respected and assured at all times

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