Journal Pre-proof

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PII: S1525-8610(20)30899-9

DOI: https://doi.org/10.1016/j.jamda.2020.10.024

Reference: JMDA 3699

To appear in: *Journal of the American Medical Directors Association*

Received Date: 9 July 2020

Revised Date: 3 September 2020

Accepted Date: 18 October 2020

Please cite this article as: RRH: COVID-19 driven visiting policies in nursing homes

Original article

Dilemmas with restrictive visiting policies in Dutch nursing homes during the COVID-19 pandemic: a qualitative analysis of an open-ended questionnaire with elderly care physicians

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RUNNING TITLE

COVID-19 driven visiting policies in nursing homes

BRIEF SUMMARY

Restrictive visiting policies impact nursing home residents and their physicians. We identified considerations relating to both infection prevention and quality of life for future visiting policies during the COVID-19 pandemic.

KEY WORDS

Elderly care, nursing homes, visiting policy, COVID-19

WORD COUNT

3281

ACKNOWLEDGEMENTS

We thank all respondents for sharing their dilemmas.

Author contributions

- Study concept and design: EMS, AAM, CMPMH, MS
- Acquisition of data: EMS, MS
- Analysis and interpretation of data: EMS, AAM, MB, CMPMH, MS
- Drafting of the manuscript: EMS, AAM
- Critical revision of the manuscript for important intellectual content: EMS, AAM, MB, CMPMH, MS

Sponsor's role

Not applicable

Conflicts of interest

The authors have no conflicts of interest to declare

ABSTRACT

Objectives: To mitigate the spread of COVID-19, a nationwide restriction for all visitors of residents of long-term care facilities including nursing homes (NHs) was established in the Netherlands. The aim of this study was an exploration of dilemmas experienced by Elderly Care Physicians (ECPs) as a result of the COVID-19 driven restrictive visiting policy.

Setting and Participants: ECPs working in Dutch NHs.

Methods: A qualitative exploratory study was performed using an open-ended questionnaire. A thematic analysis was applied. Data was collected between April 17 and May 10, 2020.

Results: Seventy-six ECPs answered the questionnaire describing a total of 114 cases in which they experienced a dilemma. Thematic analysis revealed four major themes:

(1) The need for balancing safety for all through infection prevention measures versus quality of life of the individual residents and their loved ones;
(2) The challenge of assessing the dying phase and how the allowed exception to the strict visitor restriction in the dying phase could be implemented;
(3) The profound emotional impact on ECPs;
(4) Many alternatives for visits highlight the wish to compensate for the absence of face to face contact opportunities. However, given the diversity of NH residents, alternatives were often only suitable for some of them.

Conclusions and Implications: ECPs reported that the restrictive visitor policy deeply impacts NHs residents, their loved ones and care professionals. The dilemmas encountered as a result of the policy highlight the wish by ECPs to offer solutions tailored to the individual

22 residents. We identified an overview of aspects to consider when drafting future visiting

23 policies for NHs during the COVID-19 pandemic.

INTRODUCTION

In the Netherlands, the first COVID-19 confirmed case in a nursing home (NH) was reported on March 12, 2020,[1] and by the first week of April, about 40% of Dutch NHs reported COVID-19 infections (Figure 1).[2] About 115000 people reside in one of the estimated 1000 NHs or care homes across the Netherlands,[3] for whom medical care is provided by physicians with an elderly care medicine specialty (i.e., elderly care physicians).[4] To mitigate the spread of COVID-19, strict social distancing policies were implemented by the Dutch government as of March 12, 2020. By March 19, a nationwide restriction for all visitors of residents of long term care facilities (LTCFs) including NHs was established (Figure 1).[5] This decision was made in view of a lack of alternatives as the Netherlands was facing shortages of personal protection equipment (PPE) and a lack of diagnostic capacities. The only exception of this restrictive policy included residents in the dying phase to allow a farewell moment for family members (i.e., maximum two visitors per 24 hours).[6]

It is inevitable this policy has consequences for the residents, their families and their formal caregivers. Involvement of the resident's family through visits to the NH has previously been described to be beneficial for the quality of life of residents.[7, 8] Indeed, family has been reported to promote social engagement and to strengthen identity and dignity of residents.[9] Family visits to the NH allow for the monitoring of the provided formal care as well as for additional care tasks for the institutionalized older adults.[7]

While the rationale for the restrictive visiting policy imposed to the NHs in the Netherlands was clear (i.e., to limit the further spread of COVID-19 among vulnerable populations in view of the lack of any alternatives), elderly care physicians (ECPs) in the professional network of the authors reported that the policy led to dilemmas. The aim of this study was an exploration of these dilemmas experienced by ECPs in daily practice as a result of the COVID-

19 driven restrictive visiting policy. In addition, the study aimed to provide insights in how ECPs dealt with these dilemmas. Reflecting on the experiences of the ECPs should yield valuable insights to guide policy-making in case of a second wave of the COVID-19 pandemic.

METHODS

Design

A qualitative exploratory study was performed to identify dilemmas experienced by elderly care physicians in daily practice as a result of the COVID-19 driven restrictive visiting policy in Dutch NHs.

Data collection

Discussions on the impact of the COVID-19 driven restrictive visiting policy in NHs emerged spontaneously during the weekly training days of ECPs-in-training with their academic teachers of the [department] (ES, MS). Based on these discussions, an open-ended questionnaire was designed to explore cases where ECPs experienced dilemmas and difficult situations (ES, MS, AM, CH). Questions aimed to explore whether the dilemma related to the resident, the resident's family, the nursing staff, care unit and/or organization. The questionnaire also explored the decision-making process that followed-up on the dilemmas. An overview of the open-ended questions is shown in Appendix 1. A maximum of 3 cases could be described per questionnaire participant. The web-based questionnaire (Survalyzer, Survalyzer Nederland BV) was sent to ECPs-in-training at the [UMC] and their supervisors (i.e., ECPs) by email on April 17, 2020. Recipients could forward the questionnaire to colleagues working in their institution. The questionnaire was closed on May 10, 2020 (Figure 1). All solicited ECPs were working in NHs in the central or Northern regions of the Netherlands.

Analysis

An inductive thematic analysis was applied to identify concepts and patterns of meaning in the data.[15] The analysis included the following steps: (1) familiarizing with the data, (2) inductive thematic coding, (3) searching for themes, (4) reviewing of themes and (5) finalization of themes.[15] An iterative approach (i.e., the process of going back and forth between the data, the codes and themes) was followed across the different steps to ensure a systematic analysis.

The coding of the first 14 cases was performed independently by two researchers trained in qualitative research methods (ES and AM). The results of the two independent codings were then merged into a single codebook. The codebook was used to code the remaining questionnaire data. The cases collected within the first two weeks were coded by one of the two researchers (ES and AM). Changes to the codebook (e.g., renaming of codes and addition of codes) were made in consensus between the two researchers during research meetings (ES and AM). A third researcher (MB) validated the coding by checking for inconsistencies to make sure no relevant information was missed and coded the last 20 cases. Doubts were discussed with two other researchers (ES and AM). Regular meetings between the researchers involved with the coding allowed for frequent reflections on the data analysis including the collation of codes into themes and the evolution of the identified themes. The questionnaire data were analyzed using Microsoft Word and Microsoft Excel.

Ethical Approval

All participants were informed about the aim of the study and the purpose of data collection. Formal ethical approval from a medical ethical committee was not required for this research in the Netherlands since it did not subject participants to any medical treatment or impose any specific rules of conduct on participants.

RESULTS

The questionnaire was sent to 103 ECPs-in-training and 92 ECPs and anonymously returned by 76 physicians (ECPs or ECPs-in-training). These 76 physicians, further referred to as 'ECPs', described a total of 114 cases in which they experienced a dilemmas.

Thematic analysis of open-ended questions revealed four major themes related to the restrictive visiting policy. Quotes illustrating the four themes are shown in Table 1. Furthermore, we identified dilemmas related to other COVID-19 measures in nursing homes (Appendix 2).

Dilemmas as a result of the general strict visitor restriction

The core dilemma experienced was that on the one hand, ECPs wanted to protect residents against COVID-19 infections – implying adherence to the strict visitor restrictions – but on the other hand, as a consequence quality of life of most residents seriously decreased (quote 1 and 2).

Infection prevention

ECPs encountered serious suffering as a result of COVID-19. Hence, they wanted to minimalize the risk of contamination (quote 3). According to ECPs, for some residents, the risk of contamination was acceptable but it was not just about the individual resident (quote 4). ECPs emphasized infection prevention concerned safety of all residents (quote 5) and health care professionals (quote 6).

The visitor restriction policy contributed to limiting the further spread of COVID-19. Most ECPs encountered understanding of the dilemmas they were facing among family members (quote 7 and 8), although not in all cases (quote 9).

Effect on residents' (quality of) life

ECPs used the words 'loved ones', 'partner', 'family members' and 'next-of-kin' instead of 'visitors'. ECPs considered the presence of these 'visitors' as essential to quality of life. As the majority of residents of NHs has limited life-expectancy, ECPs estimated quality of life was often considered more important than life duration (quote 10 -12). Furthermore, according to ECPs, next of kin could have provided company and support in uncertain times (quote 13). Moreover, ECPs described cases where they missed additional care otherwise provided by next-of-kin (quote 14).

ECPs described cases where the visitor restriction had profound impact on residents. ECPs observed loneliness, depressive symptoms (quote 15), decreased intake (quote 16), increase in somatic symptoms (i.e. pain) (quote 17), physical deterioration and in psychogeriatric residents rapid cognitive decline (quote 18, 19) and changes in neuropsychiatric symptoms including agitation and aggression (quote 20). The latter was even reported to result in increased psychotropic drug prescriptions for some of the residents. On the other hand, ECPs observed visitor restrictions brought peace for some of the psychogeriatric residents (quote 21). In addition, the restrictions impacted next-of-kin and nursing staff (Appendix 3).

Dilemmas as a result of the allowed exception in the dying phase

ECPs noted that although protection against contamination was irrelevant for a resident in the dying phase, protection of other residents in the institution, health care providers, next-of-kin and society remained notwithstanding important (quote 22). ECPs described the presence of visitors in the dying phase implies being surrounded with loved ones and being

able to say farewell (quote 23 and 24). We distinguished two types of issues raised by ECPs: assessing the dying phase and implementing of the exception.

Assessing the dying phase

ECPs struggle with the timing to diagnose 'dying'. The beginning of the dying phase is not always clear (quote 25). ECPs describe a grey area classified as 'preterminal phase': life expectancy is short, but the resident is not yet in the dying phase (quote 26). In these scenario's, ECPs observed residents whose last days, weeks or months were lonely (quote 27) and residents with a rapid course of the dying phase, thereby not being able to say farewell to their loved ones (quote 25). ECPs described that next-of-kin were missing the process of decline and feared this might impact their mourning process (quote 28). ECPs remarked that concluding too early that the resident was in a dying phase implies more visitors (i.e., higher risk of infection) and may set a precedent for others (quote 29).

Implementing the exception

A major aspect causing dilemmas is the number of visitors per resident. Numerous ECPs described cases where the restriction of *two visitors* implied not all close loved ones (family members) could say farewell. For example, it could cause siblings to have to choose who of them could visit their dying parent (quote 30 and 31).

Furthermore, in practice several requirements for visits were pointed out by ECPs. First, ECPs were aware that PPE was scarce, increasing the urgency to limit the exceptions (quote 32). Second, ECPs emphasized specific directives for and streamlining of the family members could limit the traffic in the institution (quote 33, 34). Last, ECPs pointed out the importance of the health of the visitor. Some direct next-of-kin (intended visitors) had or had a high risk

of having COVID-19 (quote 35) or had symptoms more or less suspect for COVID-19 (quote 36).

Impact on elderly care physicians

ECPs perceived the national restrictive visiting policy was not their decision, but felt responsible for its implementation. These feelings were in particular apparent in cases of residents with limited life expectancy as their assessment of the clinical situation would steer the decision to make an exception (quote 37). Encountered dilemmas had profound emotional impact on ECPs. They described feelings of guilt, insecurity, frustration and felt they provided suboptimal care to the residents (quotes 38-40). Some respondents described waking up in the middle of the night, worrying (quote 41). ECPs used phrases as 'Devil's bargain', 'unacceptable', 'poignant', 'inhuman' and 'unjustified' to describe some of the dilemmas they encountered (quotes 1, 41-45).

Furthermore, the visitor restrictions had some practical consequences. For example, ECPs perceived the required thorough communication and arrangements they had to make with next of kin and colleagues around the policy as extra, time consuming tasks (Appendix 3).

Diversity calls for tailored solutions

ECPs underscored the diversity of residents in, e.g., age, cognition and decision-making abilities (quotes 46-49). As a result, the impact of the restriction widely differed between individual residents. For example, the impact on a young resident who was able to maintain social contact through video calls (quote 47) substantially differed from the impact on a resident with dysarthria (quote 48) or a resident with dementia unable to understand and

use video calls (quote 49). Various ECPs indicated they missed the possibility to tailor the national policy to the individual resident (quotes 50-52).

ECPs described various alternative solutions to enable social contact between residents and their loved ones and/or social presence in the dying phase. NH organizations facilitated technical solutions (for example video calls and two-way audio connections) and alternatives to realize real-life contact at distance (for example setting up special visitor areas, crisis apartments and arranging a cherry picker enabling contact at the window). These solutions applied in some situations, (quotes 53-55) but were regularly not deemed appropriate (quote 56, 57).

The latter led ECPs to consider making an exception to the strict policy, where they faced another dilemma: it sets a precedence for others (quote 58 and 59) making it hard to maintain boundaries (quote 60). Most ECPs decided whether or not an exception should be made in a multidisciplinary setting (quote 61). ECPs reported that in some cases, next-of-kin decided to take residents back home (quote 62 and 63).

DISCUSSION

The analysis of dilemma experienced by ECPs as a result of the COVID-19 driven restrictive visiting policy revealed four major themes: (1) the need for balancing safety for all through infection prevention measures versus quality of life of the individual residents and their loved ones; (2) the challenge of assessing the dying phase and how the exception to the strict visitor restriction could be implemented; (3) the profound emotional impact on ECPs and (4) many alternatives for visits highlight the wish to compensate for the absence of face to face contact opportunities. However, given the diversity of NH residents, alternatives for

187 communication were often only suitable for some of them. ECPs missed the opportunity to
188 tailor the policy to the specific needs of the residents. Nevertheless, ECPs often assessed
189 together with colleagues, whether or not exceptions could be made for individual residents.

190 The core dilemma safety versus quality of life is encountered in various situations in NHs.[16]
191 However, the dilemmas encountered during the visitors restriction in the COVID-19
192 pandemic have an extra dimension: it is not just about protection of the resident, infection
193 prevention during the COVID-19 pandemic concerns others including other residents and
194 staff of the NHs. Interestingly, the respondents rarely used the term *visitor* to refer to the
195 persons visiting the NH resident. Thus, *visitor* seems to be an euphemistic term as it usually
196 concerns loved ones who are part of the inner circle of the resident and often a partner or a
197 close family member. Moreover, these loved ones regularly play an essential role in the
198 residents care process.[7, 17] Several authors warned about the possible consequences of the
199 absence of these loved ones, including emotional impact (e.g., loneliness, depression,
200 disruptive behaviour) and both physical and cognitive decline.[18-21] Our findings are aligned
201 with other research conducted in parallel in the Dutch NH setting.[11, 22]

202 The exception allowing for visitors in the dying phase caused struggles with the assessment
203 of *dying phase*. Dutch guidelines for palliative care define *dying phase* as last days of life.[23] It
204 is well-known that diagnosing dying is a highly complex process.[24, 25] In particular the course
205 of the new disease COVID-19 in older adults is challenging to predict for professionals,
206 causing additional uncertainty in the physicians' diagnosis of dying. ECPs in our study
207 recognized uncertainty of dying diagnosis regularly applies in NH practice. They usually deal
208 with this uncertainty by closely informing families about the residents' condition and by low-

threshold invitations to come over. The required explicit diagnosis dying under the strict visitor policy limited their possibilities to deal with this uncertainty. In addition to the diagnostically problems, the allowed exception in the dying phase raised both ethical issues and practical conditions. An ethical issue described in several cases was that *two visitors* implied not all close loved ones' presence in the dying phase was possible. Indeed, strict adhering to the conditions for exceptions cause some family members to be deprived from the opportunity to a proper farewell. Practical requirements to minimize risk of infection were streamlining visits, availability of sufficient PPE (for both health care professionals and visitors) and health of the visitor with respect to the risk of COVID-19. These requirements are recognized by others.[12, 18]

The descriptions of the profound emotional impact of the dilemmas (i.e., feelings of providing suboptimal care, guilt, injustice) illustrate the moral distress of the ECPs. ECPs missed the opportunity to make tailored decisions, affecting both their own professional as the residents personal autonomy. Furthermore, this moral distress may originate from the conflict between the visitor restriction and principles of *good care*[16]*,* including patient-centered care, shared decision-making and palliative care, that have been guiding NH care over the past decades.[17, 26] Last, making exceptions meddled with protection of and justice for other residents in the institution.

The examples of alternatives for visits (technical and at distance) underscore the urgency to compensate for the absence of visits and in the Dutch media was parallel reported on various creative solutions to allow contact at distance (e.g., using a cherry picker, 'coronatainers').[27, 28] However, alternative solutions are only suitable for some residents as

many have cognitive impairments, visual or hearing disabilities and/or speech disorders. In addition, the effect of technical solutions in decreasing social isolation in NH is limited.[29 30] In the dying phase these alternatives could not replace the presence of close loved ones who wanted to say goodbye. Consequently, ECPs deliberately weighed, whether or not a tailored exception could be made in individual cases. ECPs find it reassuring to take these decisions with a group of colleagues.

After a significant peak in the number of deaths in early April, the number of COVID-19 cases and deaths in NHs has been declining in the Netherlands.[31] On May 11th, a pilot in 26 NHs allowed for one fixed visitor, which as of May 26 applied to all COVID-free NHs; restrictions were further relaxed June 15 to allow for more than one fixed visitor and more frequent visits under certain conditions (Figure 1).[12] In our study ECPs struggled with on the one hand the pressure to adhere to the national visiting policy and on the other hand their wish for tailoring for the individual. At first, they experienced largely understanding for the situation. However, since May families have increasingly been expressing resistance against the visitor policies.[13, 14] Although there is no 'one size fits all' solution for the complex dilemmas faced here, our analysis provides several insights worth considering in assessing and reviewing current and future visiting policies. We observed that the nationwide 'top-down' restrictive visitor policy resulted in resistance and a need for more regional and local tailored visiting policies. Important aspects emerging from our study to be considered by policy makers when issuing visiting policies are the regional and local COVID-19 prevalence, the availability of sufficient PPE, the possibility to streamline visits (e.g., separate visiting areas, schedules for visitors), and the possibility to isolate residents. Nevertheless, even with visiting policies tailored to the regional and to the local NH organization context, dilemmas may still occur on

an individual level. Health care professionals may still have to weigh whether or not the local visiting policy is proportional to the specific circumstances of the resident and his or her visitors. Relevant aspects emerging from our analysis to take into account when decisions have to made for those dilemmas are summarized in Table 2. We believe explicitly considering these aspects by health care professionals should contribute to cautious decision-making. Our considerations are aligned with the reflections proposed by others on the effectiveness, proportionality and burden of COVID-19 measures in health care.[32] Furthermore, it is crucial to acknowledge that strong surveillance and diagnostic capacities are important prerequisites to facilitate individual adjustments of the policy.[18]

The strength of this work is that it provides a snapshot of the dilemmas that ECPs were facing during the epidemic's peak in the Netherlands. The described dilemmas provide valuable insights in the challenges in older adult medical practice in times of the COVID-19 crisis in the Dutch NHs (Figure 1). Our work highlights the importance of balancing infection control and prevention measures together with quality of life aspects of NH residents in future visitors policies. It also underlines the search for resident-tailored solutions by ECPs. Furthermore, the timeliness of our study together with the fact that our findings were echoed by several other studies in the Netherlands as well as several colleagues should ensure for high content validity of our results.[11, 13, 14, 33]

Our study also has some limitations. First, the data were collected through open-ended questionnaires and sent to ECPs and ECPs in training. While qualitative interviews would have potentially allowed for more depth in the answers and provided the opportunity for clarification questions, it would also have costed more time from the already over-solicited ECPs. We considered an open-ended questionnaire as a pragmatic study design to gather qualitative data that allowed respondents to reply at their own convenience. In addition,

respondents might also be prone to more honest answers in an anonymous survey. Second, we only solicited ECPs but no other health care workers, families or residents. However, the questionnaire was designed to drive reflections from different perspectives, beyond the ECP, including of the resident, his and her families as well as from nursing staff and other health care workers.

CONCLUSIONS AND IMPLICATIONS

We have shown that according to the ECPs the restrictive visitor policy in NHs deeply impacts individual residents, their loved ones and professionals. The dilemmas encountered as a result of the policy highlight the wish by ECPs to offer solutions tailored to the individual residents. We identified considerations relating to both infection prevention and quality of life to take into account when drafting future proportional visiting policies for NHs in times of a pandemic.

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Figure 1: Timeline of the Dutch responses to COVID-19 in the nursing home setting

Appendix 1: Open-ended questionnaire.

1. Please describe a situation related to the restrictive visitor's policy that led to dilemmas.
2. What affected you most in this situation? Could you describe what impact it had on you?
3. Did considerations relating to the resident play a role? If yes, which ones?
4. Did considerations relating to the resident's family play a role? If yes, which ones?
5. Did considerations relating to the nursing staff play a role? If yes, which ones?
6. Did considerations relating to the care unit play a role? If yes, which ones?
7. Did considerations relating to the organization play a role? If yes, which ones?
8. Did any other considerations play a role?
9. What was decided upon regarding the dilemma and who was involved in the decision?
10. Are there any other (not previously) mentioned considerations that should be taken into account regarding the visitor's policy?

Appendix 2: Codes and illustrative quotes relating to COVID-19 measures in Dutch nursing homes beyond the restrictive visitors' policy.

Isolation	• ”Covid negative client, displays no symptoms, has to stay in his room because the care unit is closed due to a covid positive client, family member wants to put on PPE and pick up client in PPE, to take them outside so they are no longer in a sad mood and will eat and drink again” • “Yes, that too, it would be more pleasant to be able to go outside with a few people to keep the situation on the care unit bearable. In many cases, this prevents agitation and behavioral problems among clients with dementia.”
Isolation and psychotropic drugs	• “Sedating patients who are infected and don't remain in their rooms. Isolating and sedating 'walkers', with as a result: an unpleasant end of life.” • ”Severe agitation with a PG-resident who can be calmed by family and requires more sedating medication out of necessity.” • ”Psychiatric drugs became necessary to improve the quality of life, with drowsiness and decreased mobility as a result.” • ”Sir now receives an increase of clozapine-medication, while it is unclear whether a non-medicated visit of family could be more effective.”
Freedom restriction	• The residents' world was already small, now it is even more limited because they can no longer receive family and friends, and are also locked inside the nursing home. • The fact that residents cannot go outside themselves is very restrictive and increases psychological complaints.
Freedom restriction and tailoring to residents	• “It would be nice if national policy would be that those to whom it relates, and to whom sitting in the courtyard is not enough, could go for a daily walk around the house or (duo)cycling accompanied by a member of staff.” • ”I find it difficult that they are not allowed to go outside under the condition that they have no social contact, don't go to the supermarket etc. A stroll around the block of a client with dementia accompanied by a member of staff, without any other form of social contact, should be possible.” • ”The client with the spinal cord injury has complete autonomy over his life, despite the dependence on care. He would be capable of adhering to social rules. However, he is in a total lockdown and I am in an intelligent lockdown”. • ”It feels unethical to restrict someone in their freedom, if your expectation is that he would act responsibly.” • ”In my opinion, riding around on empty parking lots or visiting quiet parks barely increases the risk of infection, but increases the feeling of freedom.” • ”Taking away the option of going out for fresh air from a cognitively competent person on an uninfected care unit, even

	when they adhere well to regulations, is something I consider a strong intervention of their right to lead their own life. The risk of spreading corona verses the restriction of freedom is, in my opinion, disproportional. ”
Communication	• ”What is difficult is that most of the contact is through telephone, there is no face-to-face contact. It makes communicating different, and more difficult.” • ”Immediate incident with a resident, rectal blood loss. Considering the stage of dementia, we will wait and see, and temporarily stop using anticoagulants Scared wife on the phone, fears cancer, cries. Reassured with difficulty. A personal conversation would have been better.”
Less help	• “There is little deployment of volunteers, spiritual care or psychologists possible, because they are also required to work from a distance as much as possible. This has caused the deployment of help with her mood to be slowed down.”
Alternatives for therapies and care	• “She currently does receive a psychologist and spiritual caretaker in her room because of the urgency, but visitors are still not allowed. An attempt will be made to improve that through videocalling or standing on the blacony with a baby monitor.”

Appendix 3: Additional consequences of the restrictive visitors' policy.

Impact on next-of-kin	• ”Family also found it very hard to hear her speech was declining as a result of ALS and they could not come to see her, to talk to her about it.” • ”Family is losing autonomy: I can see this is painful for them.” • ”The powerlessness and frustration of partner and the major worries this caused.”
Impact on nursing staff	• ”Informing families more often and better, many extra reports by nursing staff, use of video calls etcetera. Nursing staff experience this impotence too and are not always able to provide extra care.” • ”The team is more at ease as there is no traffic of various people and professionals across the care units • . Therefore, they have more time for residents. ”
Practical implications for ECPs	• ”This took a lot of effort by phone from my side to maintain a good doctor-patient relationship. ” • ”Guidance of care-teams and explaining decisions take a lot of time. ”

Table 1: Quotations of elderly care physicians illustrating the emerging themes.

I Dilemma's as a result of the general strict visitor restriction
1. "It remains a 'Devil's bargain': protecting clients from infection (keeping the outside world out) and having contact with the people you love." 2. "The dilemma concerns allowing visits for the patient's quality of life versus the risk of loved ones becoming ill and further spread in society."
Infection prevention
3. "In my nursing home, I observe how much suffering Corona causes and how many people fall victim to it. The risk of spreading should really not be taken." 4. "... for that person, it does not actually matter whether corona is an added condition (although I understand that it is about the protection of the institution and not of the individual patient)." 5. "Obviously, you want to ensure the safety of the residents in the department." 6. "Measures also protect the professionals in particular: they are very vulnerable to be infected or to spread the coronavirus." 7. "Society knows what is going on. You do not need to explain to loved ones they are not allowed to come." 8. "Remarkable how much understanding we receive from family members when we explain the dilemmas we face." 9. "Relatives who continue to argue about the framework in which visits are possible."
Quality of life <u>Importance of visitors</u> 10. "In this phase of life, quality is most important. Living secluded, away from loved ones in quarantine is not appropriate for quality of life." 11. "For patients on the psychogeriatric care units, maximizing quality of life is the main aim. To this respect, visiting and contact with loved ones is the most important thing." 12. "She literally said: now that I can no longer see my family, I have nothing left to live for." 13. "The need to allow her to be supported her in her suffering." 14. "The partner visits a patient with dementia daily. Partner helps the patient with feeding, among other things." <u>Impact of visitor restriction</u> 15. "Her fear, sadness and loneliness, very tangible and strongly present, mimicking depression." 16. "Partner explained he visited his wife with dementia daily, helped her feeding for hours. Since he has not been allowed back, she did not eat and drink enough." 17. "Several other residents who suffer more psychologically and even experience more physical pain as a result of the social suffering. As a doctor, you try to treat this but the solution is elsewhere." 18. "Still, there are several poignant cases with severe cognitive decline, partly as a result of the absence of daily contact with family, which is an essential factor." 19. "The resident is in danger of not recognizing the partner after a long time, in particular when video calls are not understood." 20. "Increase of behavior problems, in particular agitation and physical contact towards nursing staff after the wife was not allowed to be with her husband in the afternoon. Causes an increase in psychotropic drug use and major pressure on nursing staff." 21. "No visits also results in peace on the care units. For some of the people it is very hard, but another part is more calm and thrives."
II Dilemmas as a result of the exception in the dying phase
22. "The dilemma is allowing visitors from the angle of quality of life for the patient, versus the risk of infection from loved ones and further contamination into society." 23. "The right to being surrounded by family as you pass away." 24. "A goodbye in person is something I see as very valuable."
Assessing the dying phase
25. "Wife was asked to husband short before he passed away, sometimes it is hard to estimate being terminal. Then we are too late. This occurs sometimes, also during normal times, but then the family would already have had the opportunity to say goodbye when the patient became ill." 26. "Is the daughter allowed to visit her mother despite the mother not being terminal yet, but while she is still communicative." 27. "His last days/weeks/months are lonely." 28. "I would not be surprised if this resident passes away during the corona crisis from something other than corona. It is tough for the family that they are not able to follow this process, not until he is on his deathbed. The processes of saying goodbye and acceptance are much harder to start." 29. "If we allow visitors now, we might have to allow it with others as well."
Implementation the exception

30. “That I have to decide how many family members can say goodbye or not. Conflict between adhering to policy and rules and the human dimension.”
31. “Mrs with 4 daughters (...) You can’t let children decide amongst themselves who is allowed to visit, right?”
32. “Allowing low-threshold visitation (if life-expectancy is uncertain) we will have even fewer PPE at our diposal, since family also needs to wear PPE.”
33. “Patient was terminal and visitors were allowed, a maximum of 2 people per day. Except, these two would walk in and out throughout the day (…) This made me realise that the policy of ‘two people a day in the terminal phase’ is not specific enough. Are they allowed to walk in and out? How long are they allowed to stay?”
34. “Nursing was given the job and responsibility to lead the process of visiting which went well, but it was scary for them.”
35. “The care unit was still covid-free at that point. The risk of infection coming in with this family was deemed high, due to contact with the covid-positive wife who had passed away.”
36. “Family was invited to come visit sir. 9a maximum of 2 people at a time, without symptoms and without a fever). The eldest daughter has coughing complaints, chronically according to her. How do you make a decision in a case like that.”

III Impact on Elderly Care Physicians

37. “The fact that I had to decide whether a son could see is mother was something I found agonizing, while it wasn’t even necessarily my decision in the first place, it was the government’s decision.”
38. “Sub-optimal care. Normally in these situations, family that could help with care are now shut out. Is this a good decision?”
39. “Seeing agitation increase, and knowing that family could have a positive influence but not being allowed to allow them in and having to explain that to the family. Feels terrible. Painful. Poor quality of care.”
40. “But sometimes it is so unexpected when it comes to COVID, it makes me feel scared that I am withholding a goodbye from family and patient.”
41. “Impotence to find a good solution. It occupies my mind, day and night.”
42. “This is unacceptable, I feel I am falling short, powerless and also angry at this entire situation. Inhumanly sad, it deeply affects me.”
43. “Very poignant, this should not have happened this way.”
44. “So tangible (...) it is such an inhumane happening and I am personally having a really difficult time with this decision.”
45. “It gives you a real feeling of injustice and doubt about whether something weighs up against the risk that comes with allowing visitation.”

IV Diversity calls for tailored solutions

<u>Diversity</u>

46. “It is a young man with a one-sided paralysis after a CVA, but he is cognitively well. He can make informed considerations en express himself well.”
47. “Relatively young patient, with MS with severe paraparesis (...) She is able to communicate with loved ones via several forms of media.”
48. “She can’t express herself well, verbally., which makes communication through the telephone or video calls not possible, which creates more emotions and frustrations.”
49. “Communication with daughter through video calls led to more agitation, paranoia and delirious phenomena.”

<u>Tailoring</u>

50. “Really account for the humanity. As per usual, also in this case, we weigh the risks, not only to the patient but also to their loved ones and the nursing staff.”
51. “The government policy is not pleasant. There is too little attention for proportional decision-making and tailoring.”
52. “Individual tailoring is strongly preferred, especially when considering the rights of the hospitalized patient.”

<u>Solutions</u>

53. “It also depends on location. Some places have gardens where visitation “at the gates” works really well.”
54. “On the ground floor we were able to make arrangements that the rest of the family could stand at the window to be a part of the moment [ritual when passing away] with the pastor.”
55. “Audiofiles of sir, that could then be played back.”
56. “On scaffolding in front of a window also won’t work, mrs does not understand that and it will only end in drama.”
57. “When you’re sick, a videocall is not enough.”
58. “Allowing the husband onto the care unit would most likely have caused such unrest and aggravation with other patients that we decided against it.”
59. “If you make an exception for one person, then why not for the other. Who is suffering the most under this measure.”
60. “Because then more cases would qualify for this exemption which would make it hard to safeguard the boundaries (in consultation with the local crisisteam).”
61. “A decision was made with all involved disciplines (nurse, supervising elderly care physician, teamleader, psychologist).”

62. “Eventually the husband decided to take the patient home for an indefinite amount of time. Not ideal because of the severity of care, but when weighing the risks they still made this decision.”
63. “Client with many children discharged themselves for terminal care at home so that everyone could say goodbye at home. Eventually satisfactory for the family, though still hectic in a terminal phase.”

Table 2: Aspects to be considered around dilemmas caused by visiting policies

Level	Considered aspects
Resident	Residents' view on risk of COVID-19
	Connotation of receiving visitors for resident: • Saying goodbye to loved ones • Presence in the dying phase • Receiving additional care • Mutual support in crisis • Impact on quality of life
	COVID-19 confirmed?
	COVID-19 related symptoms?
	Life expectancy: • Months to years • Weeks to months • Dying phase
	Symptoms as a result of the visitors restriction**, for example: • Loneliness • Depressive symptoms, depression • Decreased intake • Neuropsychiatric symptoms (increased or decreased) • Physical complaints (for example pain) • Physical or mental deterioration
	Are alternative solutions for social contact applicable and satisfactory? • Technical solutions • Creative real life solutions
	Are alternative solutions to decrease symptoms proportional?
Visitor	COVID-19 confirmed?
	COVID-19 related symptoms?
	Connotation of visiting the resident for specific visitor: • Being able to say goodbye to loved one • Being involved in resident's disease process/ process of decline • Being involved in resident's care process • Being involved in resident's daily life • Mutual support in crisis • Impact on quality of life visitor
	Has specific visitor a structural role in the care process: • Assisting with intake • Assisting in communication, i.e. in case of dysartria or language barrier • Involved in daily routine
	Are alternative solutions for social contact applicable and satisfactory for the specific visitor? • Technical solutions • Creative real-life solutions
	Sufficient availability of personal protection equipment for visitors?

NB: Several aspects are illustrative, this is a non-comprehensive list.
*or care unit; ** as estimated by the physician

Figure 1: Timeline of the Dutch responses to COVID-19 in the nursing home setting

- March 12, 2020: First confirmed COVID-19 case in national nursing home registry.[1]
- March 12, 2020: Social distancing policies implemented by the Dutch government.[10]
- March 19, 2020: Nationwide restriction for all visitors of residents of LTCFs including NHs.[5]
- April 17, 2020: Start of data collection/questionnaire sent to ECPs.
- May 10, 2020: End of data collection/questionnaire closed.
- May 11, 2020: Start of a pilot with eased visiting policies (i.e., allowing for one fixed visitor) in a selection of 26 Dutch NHs.[11]
- May 26, 2020: Eased visiting policies (i.e., allowing for one fixed visitor) in all NHs free from COVID-19.[12]
- June 10, 2020: First monitoring results of the pilot published by the Collaboration of Academic University Networks for Older Adult Care in the Netherlands.[11]
- June 15, 2020: Stepwise lifting of restrictive visiting policy (i.e., allowing for more than one fixed visitor and more frequent visits) for all NHs under certain conditions including COVID epidemiology and organizational factors.[12]
- June 28, 2020: Researchers from two Academic University Networks for Older Adult Care commissioned by the Dutch Ministry of Health advise against a nationwide visitor restriction and argue that NHs should implement tailored visitor policies upon a second wave of COVID-19.[13, 14]