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Recommendations Related to Visitor and Movement Restrictions in Long-Term Care and Retirement Homes in Ontario during the COVID-19 Pandemic: Perspectives of Residents, Families, and Staff

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Article

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Résumé

Au Canada, les aînés qui vivent dans des établissements de soins de longue durée et dans des maisons de retraite ont été sévèrement affectés par la pandémie de COVID-19. Pour protéger cette population, les autorités ont imposé des restrictions dans les résidences, dont l'interdiction de se déplacer dans les établissements et d'accueillir tout visiteur. Ces restrictions ont entraîné de graves répercussions sur la santé et le bien-être des résidents. L'engagement auprès des résidents qui ont été le plus touchés par de telles restrictions peut nous aider à mieux comprendre leur vécu et répondre à leurs besoins. Dans le cadre de cette étude qualitative, 43 participants – résidents, membres de la famille et membres du personnel soignant de ces établissements – ont offert des recommandations concernant le contrôle des infections, la communication, les contacts sociaux, les soins et la planification. Ces recommandations ont été analysées à l'aide d'un cadre déontologique afin d'en déterminer la pertinence éventuelle dans l'élaboration de politiques de gestion des crises sanitaires. Les résultats illustrent les dommages causés par la restriction des déplacements et des visites et soulignent la nécessité de concevoir et mettre en œuvre des mesures efficaces, équitables et transparentes. La conception de politiques pour les établissements de soins de longue durée et les maisons de retraite exige un engagement constant et approfondi avec les personnes les plus touchées.

Abstract

In Canada, long-term care and retirement home residents have experienced high rates of COVID-19 infection and death. Early efforts to protect residents included restricting all visitors as well as movement inside homes. These restrictions, however, had significant implications for residents' health and well-being. Engaging with those most affected by such restrictions can help us to better understand their experiences and address their needs. In this qualitative study, 43 residents of long-term care or retirement homes, family members and staff were interviewed and offered recommendations related to infection control, communication, social contact and connection, care needs, and policy and planning. The recommendations were examined using an ethical framework, providing potential relevance in policy development for public health crises. Our results highlight the harms of movement and visiting restrictions and call for effective, equitable, and transparent measures. The design of long-term care and retirement policies requires ongoing, meaningful engagement with those most affected.

Introduction

Older adults living in long-term care and retirement homes have experienced severe impacts of the COVID-19 pandemic. In Canada, these older adults experienced the highest rates of infection and death (Canadian Institute for Health Information [CIHI], 2021), and faced significant physical and social isolation related to movement and visiting restrictions (Baumann & Crea-Arsenio, 2022; Saad et al., 2022; Thirsk et al., 2022). Measures that restricted residents' movement within the homes and prevented visitors appeared reasonable early in the pandemic, yet as the pandemic progressed and restrictions variably eased in the community, they remained highly restrictive in the homes, potentially harming the overall health and well-being of residents (Low et al., 2021). To mitigate the continuing impacts of the COVID-19 pandemic, it is opportune to learn from those who experienced these measures. In this article, we present the perspectives of

long-term care and retirement home residents, their family members, and staff, with respect to recommendations for navigating the ongoing and future public health crises.

Background and contextual information

Long-term care and retirement homes have been contexts of critical concern throughout the COVID-19 pandemic. In Ontario, where this study was conducted, long-term care homes provide housing and services for adults who require 24-hour nursing care or personal care, frequent assistance with activities of daily living, and supervision to ensure their safety (Ministry of Long-Term Care, 2022). Retirement homes are defined as residential complexes or part of residential complexes primarily occupied by persons aged 65 years or more, of whom at least six are not related to the owner, and in which the operator offers at least two direct or indirect care services as per the Retirement Home Act (O. Reg. 166/11, 2022). It is assumed that older adults living in retirement homes are more independent and require less support than those in long-term care homes; however, given the reluctance to relocate after settling into a retirement home and long waitlists for long-term care, many older adults are living longer in retirement homes (Picard, 2021). Increased care needs are managed through additional services, paid privately or through home care programs (Picard, 2021). In other words, while residents of long-term care tend to have more intensive care needs than residents of retirement homes, there is a fair amount of overlap between these populations with regard to function.

In Canada, residents of long-term care and retirement homes, primarily older adults facing intersecting medical and social vulnerabilities, have experienced substantial harms over the course of the pandemic, such as disproportionately high rates of illness and death (CIHI, 2021). Residents have been deprived of opportunities to connect with their families and others residing inside and outside of these homes, contributing to heightened social isolation and mental health challenges (Baumann & Crea-Arsenio, 2022; CIHI, 2021; Saad et al., 2022). Families have grappled with restricted access to care homes, posing barriers to engagement in residents' care and well-being (CIHI, 2021; Saad et al., 2022; Thirsk et al., 2022). Staff has been tasked with navigating challenging and changing work demands under conditions of staff shortages, high turnover, and inadequate resources (Kirkham et al., 2022; Siu et al., 2020).

In the province of Ontario, the Ministry of Health and Long-Term Care instated directives and policies to address emergent challenges throughout the pandemic. While there are differences in the ways that retirement homes and long-term care homes are regulated, retirement homes implemented pandemic policies similar to those implemented in long-term care (Ministry of Health, 2023). These policies have been updated as the pandemic has progressed. For instance, early in the pandemic, all individuals (e.g., family members, clergy, and other non-staff personnel) were strictly prohibited from visiting long-term care and retirement homes across Canada, with some exceptions for severely ill or dying residents (Ministry of Health, 2020). Resident movement and activities within homes were curtailed with many reports of older adults being confined to their rooms for days on end (Mahoney, 2020; Picard, 2020). Residents were gradually permitted in-person outdoor visits during summer 2020 (Government of Ontario, 2020; Ministry of Long-Term Care, 2020), though policies of specific homes and regions affected the nature, timing, and duration of visits. On September 2, 2020, the concept of *essential visitors* was introduced, referring to 'individuals performing essential support services or those visiting a very ill or palliative resident' (Government of Ontario, 2020). With this change, residents were allowed one or two essential visitors to visit if they had proof of a recent negative COVID-19 test and the home was not under outbreak (Government of Ontario, 2020).

Policies related to the COVID-19 pandemic in Canada have been presented as aligning with a growing evidence base comprised of emerging research findings and recommendations from key stakeholders including researchers, residents, families, and healthcare workers. In this study, we aim to contribute further evidence to inform recommendations for future policy development by presenting the perspectives of residents, families, and staff of long-term care and retirement homes in Ontario during the pandemic. This research is part of an overarching study exploring the experience of visiting restrictions in long-term care and retirement homes in Ontario during the COVID-19 pandemic, approved by the Hamilton Integrated Research Ethics Board (HiREB # 11426).

Methods

Older adult residents of long-term care and retirement homes in Ontario, family members or informal caregivers of residents, and staff working at these homes during the pandemic were recruited for the study. Given the intent to include individuals associated with various care homes across the province, we recruited through social media, sharing a recruitment poster via platforms of Facebook, Twitter, and Instagram within the researchers' personal and professional networks during fall 2020, spring 2021, and fall 2021. Additional participants were recruited through snowball sampling whereby participants were asked to refer others meeting inclusion criteria. Included participants were residents of Ontario long-term care or retirement homes and had resided in the setting prior to March 2020 as well as between March 2020 and January 2022 to ensure that they had experience living in the setting both prior to and during the pandemic; family members of such residents; or staff who had worked in these homes both prior to and after March 2020.

The research team consisted of individuals with expertise in older adult health and social care, mental health, long-term care and retirement homes, occupational therapy, bioethics, epidemiology, and qualitative methods. One-on-one semi-structured interviews were conducted by a trained research assistant or one of the authors via telephone. Questions centred on the specific experiences of the participants (i.e., of residents living in, family members caring for residents, and staff working in long-term care and retirement homes). All participants were asked to discuss the implications of movement and visiting restrictions on residents' daily lives, physical and mental health, and functioning in daily activities. All participants were directly prompted to provide recommendations for ways of managing present and future pandemic situations. Interviews were audio-recorded and professionally transcribed; transcripts were analyzed using methods of qualitative description informed by Sandelowski (2000, 2010). In alignment with methods of qualitative description, two of the authors read the transcripts repeatedly to familiarize themselves with the data before independently coding the transcripts using an inductive and deductive coding scheme informed by the research question. After having coded two transcripts each, the two authors met to refine the coding scheme before each coded the remainder of the transcripts.

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Quirkos software was used to organize the data and facilitate the coding process. The same two authors then reviewed the coded data, organized the codes into categories, and independently developed initial themes. Reflective memos (Bodgewick, 1999) were created throughout the process of analysis to capture insights, patterns, and discrepancies. The two authors subsequently met to refine the themes prior to presenting them to a third author; after further refinement, the three authors agreed on the final themes.

Results

Interviews were conducted between September 2020 and January 2022 with a total of 43 participants: 2 residents of long-term care or retirement homes, 30 family members, 9 staff members, and 2 individuals who were both family members and staff members. All family member participants were directly involved as caregivers for a long-term care or retirement home resident, meaning they were actively involved in care decisions and had visited with their family members at least once a month prior to the pandemic. Staff participants mostly provided direct care to residents (n = 8), with few in administrative positions (n = 3). Overall, participants were associated with 22 long-term care and 14 retirement homes across rural and urban areas of Ontario, giving a wide breadth of perspectives. The average length of interviews was 50 minutes.

In our interviews, residents, families, and staff members of long-term care and retirement homes offered recommendations about various practices. Specific recommendations have been categorized under broad interrelated themes of (a) infection control, (b) communication, (c) social contact and connection, (d) care needs, and (e) policy and planning.

Infection control

Participants from all perspectives suggested measures to reduce transmission within homes and increase safety to allow visits.

Participants supported the use of personal protective equipment (PPE), as well as requiring hand washing and sanitizing, physical distancing, and vaccination. As one resident participant shared, 'wearing a mask is not that pleasant, but you have to do it for the safety of others and yourself' (R2). Participants speculated that such measures would increase safety and therefore enable visits: 'with sanitizing your hands, wearing a mask and [physical] distancing, I would like to think that it's pretty safe for me to go to my mom's suite and spend some time there' (F24).

Participants noted that while infection-control procedures were enacted as the pandemic advanced, ongoing adherence varied. Family participants in particular observed gaps in adherence to infection-control protocols, such as inconsistent and improper use of PPE by staff. It was recommended that staff obtain more rigorous infection-control training to establish common understanding and promote adherence. Family participants further recommended that staff actively enforce infection control within homes and be provided with the resources to do so:

> If people are properly trained, it can be safe. But you need the extra resources because you need someone at the door to be screening people, and you need to help people with their training, and you need to have that extra supply of PPE.… If [this dedicated role] doesn't come with the extra resources, it just means that the staff again gets stretched too thin. (F15)

This participant proceeded to discuss how the implementation of a paid or volunteer role dedicated solely to infection control could be beneficial in ensuring that new staff were adequately trained and followed stringent infection-control procedures.

In relation to physical distancing, family participants noted that having multiple residents share small bedrooms not only increased the risk of transmission, but also imposed restrictions for residents to quarantine if their roommate(s) had external appointments. To address these challenges, participants recommended that the number of residents living in each room be reduced.

Communication

Many participants reported that communication from the care homes with both residents and family members was inadequate.

Family and staff participants noted a lack of communication between residence administration and residents, especially to address uncertainties residents may have had about visiting restrictions and home outbreak status. One staff participant reported that when left unaddressed, residents' confusion resulted in them feeling blindsided and discontent:

> There were people who were confused about the rules…, and [who] didn't know what was going on. And that just made them not more angry but just more annoyed once they understood what they had to do. It seemed to come out of the blue. (S3)

It was recommended that homes maintain clear and timely communication with residents through channels tailored to their capacities.

Approximately a third of family participants reported receiving inadequate and/or inconsistent communication from residence administration, specifically about updates on resident status, changes in care, and visiting restrictions. Receiving no communications or responses to repeated inquiries was identified as a significant challenge and frustration. It was recommended that homes provide communication that is 'honest, open and relatively frequent' (F24). One family participant noted, 'I would recommend good, immediate communication when something happens [e.g., policy or status change]… even if it meant getting onto the phone and calling families. Email… Just letting people know right away' (F17). Other recommendations included relaying information through regular townhalls, using social media to share photos of resident activity, and designating a single point of contact on the team to communicate with families and streamline sharing of information. These methods were reported to have been implemented by some homes and appreciated by the family and staff participants describing them.

Beyond enhanced communication from residence staff and administration, family participants noted the potential value in collaborating with homes to best support resident and family needs.

> They could have worked with the family to try and figure out what to do in situations; they could have figured out how to increase communication; they could have figured out all of these things. They could have figured out how to have access to people in a safe manner. (F5)

Although some family participants recognized that care home staff managed numerous responsibilities during the pandemic, they still identified that being promptly informed of changes to residents'

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needs or status, as well as of restrictions and processes, could and should be a high priority.

Social contact and connection

While several family participants expressed understanding the rationale behind restrictions, many criticized the duration for which they were implemented and described the consequent lack of social contact as detrimental to residents' health and well-being:

> You cannot take the resident's support away for a long period of time. I get the initial lockout. I think we all do. But there was a certain point in time when we knew the distancing, PPE, staff working in one place [were helpful].… we had everything in place… [visitors] could have safely been reintegrated… the harm that was done is irreversible – physically and cognitively. … My mom will never get that back. (F8)

In order to minimize further harm, participants offered recommendations to enable safe social contact both among residents and with families.

According to family participants, some homes implemented restrictions that kept residents in their rooms, limiting residents' opportunities to interact with each other. One family participant asserted, 'they have to stop treating it like a jail. Because that's the way it's been feeling to people. In fact, my mother referred to her room in the early days as her cell' (F12). One staff participant suggested that residents of similar risk level be allowed to choose 'bubbles' or groups of residents in which they could socialize and isolate to maintain some contact. A family participant proposed the similar idea that small groups of residents could regularly eat together in dining areas during alternating time slots, adhering to safe capacity limits and physical distancing rules. It was also recommended that homes facilitate opportunities for residents to engage socially in outdoor spaces, given the decreased risk of transmission.

Participants made suggestions for allowing visitors from outside the homes while upholding infection-control protocols. Window visits were proposed with the resident situated inside near a window and visitors outside. Indoor visits were suggested to take place using floor-to-ceiling plexiglass dividers and in well-ventilated spaces sufficiently large to enable physical distancing and routinely cleaned between groups of visitors. Family participants also suggested making use of outdoor spaces with heating to host visiting in colder conditions. One participant compared this to how restaurants were adapted: '[it] was just brilliant in that [patrons are] outside but they're in sort of tents with heaters. I think that type of an environment or somewhere where people could at least go and gather and talk that reduces the restrictions or provides an opportunity to socialize' (F3). Fence visits were described by one family participant as a variation of outdoor visits that allowed residents and families to engage outside at a safe physical distance, separated by a fence. Family and staff participants agreed that infection-control protocols as described above should be maintained during visits.

An option described to promote social connection while reducing in-person contact was the use of virtual communication, but which was constrained by variable access to technology as noted by family and staff participants. One staff participant reported:

> Obviously [technology is] a big budget consideration. Those [iPads] were super instrumental in the time before we were able to do in-person visits. … the phone lines in the home weren't an option to mediate all the calls that were coming through. And the iPads, we had five of them for a home with about 100 people in it. (F4/S1)

It was recommended that homes invest in technology (e.g., acquiring an adequate supply of devices to support virtual communication) to ensure residents had opportunities to communicate with their families and others, especially when in-person visiting was difficult due to any circumstances. In some homes, amenities, including wireless internet, were only available at additional costs, which posed a financial barrier for residents even if they had access to devices. One family participant recommended that such amenities be complimentary or included in living costs to enable resident contact with those outside the home.

The loss of social contact and connection was seen as having significant implications; family and staff participants stated that investments to modify physical structures, promote infection-control protocols, and provide technology could enable contact while minimizing risks of infection.

Care needs

Family and staff participants identified that although restrictions may have reduced transmission risks, in many cases, they prevented residents' care needs from being met; participants thus made recommendations for ensuring comprehensive resident care throughout the pandemic.

Multiple instances were described in which residents did not have access to their family doctor, proper grooming and footcare, or other services. One staff participant recommended that these services be treated as essential and permitted in alignment with infection-control protocols (e.g., in residents' rooms and using PPE). Family participants recounted that they were seldom informed if residents' care needs had changed or were not being met. They also expressed not knowing if important items (e.g., glasses, hearing aids, or footwear) required repair or replacement, and that without such knowledge, they could not address the issue or advocate for residents' needs.

Participants identified that residents' mental, in addition to physical, healthcare needs were neglected as well. Residents were living through an unprecedented situation given both the movement and visiting restrictions and the experience of co-residents falling ill and dying. One family participant expressed:

> My mom and dad are in a place where they're meeting people and then all of a sudden one of them gets sick and dies…. they need somebody in there to talk not only about COVID stress [but also] how things they're experiencing are normal and maybe some coping mechanisms, but also grief and bereavement. (F10)

It was expressed that residents required mental health services that may have been provided in usual circumstances but were not offered during the pandemic.

Family participants expressed approval of the policy designating and allowing essential caregivers to visit, which helped to address some needs. One participant described this policy as a 'safe way of allowing family into the home… mitigating all of those very deep harms of social isolation and people not having access to their loves ones' (F15).

Participants emphasized that broader consideration of residents' care needs throughout the pandemic was required.

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Policy and planning

Finally, participants identified a need for updated policy and planning at the levels of care homes and provincial and federal governments.

At the level of care homes, family participants recommended that 'regularly updated emergency plan[s]' (F22) be developed and maintained in preparation for potential public health emergencies. One family participant shared:

> First and foremost is preparedness. I think this [pandemic] caught the industry off-guard. Companies do business-continuity planning all the time and yet the long-term care homes just… it wasn't even a blip on the radar. That's a bit shocking to me. (F6)

Such plans could include collaborating with community resources, such as 'hospitals… or government organizations' (F1), and consulting professionals (e.g., physicians and infection-control staff) to provide a coordinated response that adequately addresses the needs of individuals and communities.

Participants recommended that crucial to meeting the needs of residents and families was ensuring safe and secure working conditions for staff in care homes. It was suggested by a family participant that the staff workload was too high and the pay too low, particularly under pandemic conditions. Poor working conditions were described to ultimately influence the timeliness, quality, and safety of care. Staff participants mentioned how respect for and collaboration with staff are key components of building a safer work environment: 'nursing staff, who are working the frontlines, ask them what works best, what doesn't. Just keep open communication and ask for input' (S8). In some locations, staffing numbers were increased and one staff participant described how this resulted in better care because 'we got to know all about [the residents] individually, and their quirks, their likes, their dislikes, and what makes them laugh, what makes them upset' (S9). Or as another staff participant said, 'we're their family when their family can't be there' (S5).

At the provincial level, multiple recommendations were made about governmental directives. Family participants pointed to a lack of specificity and clarity in directives from the Ministries that led to differential interpretations by individual long-term care and retirement homes. One participant described:

> I think the Ministry needs to be more directive. Some of the 'directives' that were out had permissive language… not 'the licensee shall', it was 'the licensee may'. Well, no, because then you have people interpreting and there's too much wiggle room. (F6)

Participants identified discrepancies in practices across care homes. It was recommended that the directives minimize room for interpretation to enhance consistency across homes.

Another directive-related recommendation pertained to the requirement for essential caregivers to have biweekly COVID-19 PCR tests to enter homes. In many communities, especially earlier in the pandemic and in more remote areas, accessibility to such tests was difficult, which rendered this requirement a significant barrier. One participant described, 'I've been driving half an hour to a hospital out of town [to obtain a test]' (F9). In November 2020, when testing demands evolved, another participant lamented the lack of access to rapid testing: 'tests are only good for the minute that they're taken. So if you are waiting 14 days… if you are asymptomatic any time within those 14 days, you can be carrying the virus and you don't know it' (F18). It was recommended that should policy mandate regular testing for families of residents, testing be made readily accessible.

Many family participants proposed that the current model of for-profit care homes be re-evaluated. For-profit homes were described to have conflicting priorities: 'those companies are in the business of delivering profit to shareholders. They're not in the business of taking care of people' (F15). A second family participant stated, 'they put liability as their priority versus continuing to recognize they're there to deliver care for residents. And so we need to shift the model in Ontario back to… patient-focused or resident-focused care' (F6). Participants expressed disapproval at how for-profit homes tended to adopt practices that prioritized profits, which may have decreased the quality of care and in turn residents' well-being.

All recommendations in the preceding themes require adequate staffing and resources, which participants suggested could be addressed through the creation and implementation of national standards for long-term care and retirement homes. One participant asserted, 'Canada needs national standards for long-term care. They should be developed together by the provinces, the territories, and the federal government' (F15). This participant further stated that such standards should address staffing ratios, minimum salaries, direct care allotments for each resident, as well as quality and quantity of activities (Table 1).

Discussion

Using an ethical framework to analyze the issues and recommendations raised in this study can provide insights to inform policy development in current and future pandemic situations. Moore (2022) identified key public health values to evaluate the ethics of hospital visitor restrictions. Given that hospitals and long-term care and retirement homes adopted similar restrictions during the COVID-19 pandemic, the application of this framework to the long-term care and retirement home sector may be similarly fruitful. In this section, we draw on Moore's (2022) framework, applying the public health values of *proportionality, least infringement, effectiveness, necessity,* and *public justification*, as well as existing research, to examine our results.

In her conceptualization of *proportionality,* Moore specified that 'the expected public health benefits associated with an intervention should outweigh the harms associated with infringing other moral considerations, such as individual rights' (2022, p. 73). Further, Moore suggested that to uphold the value of *least infringement*, any infringement upon moral considerations ought to be 'minimized and as non-intrusive as possible' (2022, p. 74). Many participants in our study expressed that visitor restrictions were enacted with intentions to protect residents from infection, but that the harms unduly exceeded the benefits of maintaining such restrictions. The protection conferred by visitor and movement restrictions was narrowly focused on reducing the risk of COVID-19 infection, neglecting consideration of innumerable factors that importantly contribute to resident health and well-being, such as engagement with family (Egan et al., 2014; Hindmarch et al., 2021; Mackenzie, 2022). Family members act as 'essential caregivers who fulfil a vital and essential role in the daily care and general well-being' of residents (Thirsk et al., 2022, p. 1416), but were not treated as such according to our participants. Without access to the residents, family members could not care for and advocate on behalf of them. Visitor restrictions have been associated with severe

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Table 1. Specific recommendations proposed by participants, organized by theme

Theme	Recommendations
Infection control	Care homes were recommended to: 1. continue implementation of infection control protocols (e.g., using PPE, hand washing/sanitizing, physical distancing, and vaccination); 2. uphold adherence to these protocols through training and enforcement; and 3. reduce the number of residents per room to follow physical distancing requirements
Communication	Care homes were recommended to: 1. engage in clear, appropriate, timely and consistent communication with residents to promote understanding of pandemic information and restrictions; 2. engage in 'honest, open and relatively frequent' communication with family members regarding resident needs/care and policies, through channels such as phone, email, townhalls, and social media; and 3. collaborate with family members to problem-solve how best to support residents' and families' needs
Social contact and connection	Care homes were recommended to: 1. enable residents of similar risk levels to form their own 'bubbles' or groups of residents with whom they could isolate, eat, and engage; 2. create opportunities for outdoor social activities among residents; 3. facilitate visits between residents and family members while upholding infection control protocols through window visits, outdoor visits, and indoor visits (e.g., using plexiglass dividers and large ventilated spaces); and 4. invest in and use technology to facilitate virtual interactions between residents and family members
Care needs	Care homes were recommended to: 1. facilitate access between residents and external services relevant to residents' comprehensive care needs (e.g., primary, oral, eye, and foot care); 2. offer mental health support for residents to cope with challenges in residential care and pandemic contexts; and 3. continue to permit family member visits in alignment with the essential caregivers policy
Policy and planning	Care homes were recommended to develop emergency plans and collaborate with community resources to better prepare for addressing future public health crises Governments and Ministries were recommended to: 1. create more accessible avenues for COVID-19 testing; 2. enhance the specificity and clarity of directives to minimize differing interpretations between care homes; 3. enhance the safety and security of working conditions for staff of care homes; and 4. re-evaluate the current model of for-profit care homes

disruptions to essential care provided by family members and other care professionals, contributing to the deterioration of residents' physical health and functioning (Baumann & Crea-Arsenio, 2022; CIHI, 2021; Hindmarch et al., 2021; Kirkham et al., 2022; Thirsk et al., 2022). In addition to losses in contact and connection between residents and their families, our participants described restricted movement within homes, with residents confined to their rooms, unable to interact with one another. One participant likened the living conditions of their home to a jail. Comparisons between long-term care homes and prisons have been made by residents and families more broadly in Canada (Thirsk et al., 2022), underscoring a substantial erosion of autonomy experienced by residents during the pandemic. Increased social isolation, depression, and other negative mental health outcomes for residents have been related to visitor restrictions and losses in connections with families (Baumann & Crea-Arsenio, 2022; CIHI, 2021; Saad et al., 2022; Thirsk et al., 2022). The significant harms of visitor restrictions on the health and well-being of residents seemed to have outweighed the benefits of supposed protection against infection, undermining Moore's (2022) values of *proportionality* and *least infringement*.

According to Moore (2022), the value of *effectiveness* is related to whether public health goals are met by an intervention. This value can guide examination of the degree to which restrictions mitigate COVID-19 infection, illness, and death. In Ontario, visitor restrictions were among a host of public health measures, including physical distancing and PPE use, instituted in parallel by the Ministry of Health (2023). It was difficult to disentangle the effects of visitor restrictions from other concurrently implemented measures (Moore, 2022). Conducting mass testing, using PPE, screening for symptoms, implementing cohorting, and practicing hand hygiene were effective infection-control procedures adopted to respond to the pandemic (Frazer et al., 2021). Vaccinations have also been demonstrated to be effective at protecting against COVID-19 infection and severe outcomes among long-term care residents in Ontario (Brown et al., 2021b; Grewal et al., 2022). Our participants recommended allocating fewer residents per room, which was consistent with the finding by Brown et al. (2021a) of greater COVID-19 infection rates in Ontario long-term care homes with multiple-occupancy, relative to single-occupancy, rooms. Recommendations by our participants for continued use of specific infection-control measures while allowing in-person visits were generally in alignment with published evidence; in a scoping review by Dykgraaf et al. (2021), several studies were identified to show success in trialing visits early in the pandemic using infection-control measures in residential care facilities with no increase in COVID-19 infections. All this evidence raises doubt about the *necessity* – which Moore (2022) described as there being no other option – of visitor restrictions as opposed to other means associated with less harm.

In Ontario, on September 2, 2020, regulation was introduced for residents to designate essential caregivers who would have visiting privileges with fewer restrictions. Though our family participants found that this policy came too late, they appreciated it and recommended it be sustained. Saad et al. (2022) showed that other long-term care residents in Ontario similarly derived great benefit from regained access to family members as essential caregivers. In both our and Saad et al.' (2022) studies, however, participants noted practical barriers to visits by essential caregivers, such as delays obtaining COVID-19 test results, later addressed by more

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accessible rapid testing. Such barriers should be considered and addressed in subsequent policy decisions.

Participants also recommended the use of technology to facilitate connection between residents and their families outside the care homes during the time when visiting was prohibited. The use of such means, however, was sometimes impeded by an insufficient availability of devices or financial costs of accessing the internet. More broadly, the effectiveness of visits using technology remains uncertain due to inadequate infrastructure affecting implementation, variable familiarity and comfort with technology, and additional burden to staff for facilitation (Chu et al., 2022; Giebel et al., 2023; Saad et al., 2022). Nonetheless, technology could be leveraged constructively should access to resources be assured; for example, McArthur et al.' (2021) found that during the lockdown of long-term care homes in New Brunswick, virtual visits, facilitated by designated staff and an adequate supply of tablets, contributed to mitigating negative mental health outcomes among residents.

Window, fence, and outdoor visits were also identified by our participants as possible alternatives to traditional indoor visits. These in-person alternatives have been described by family caregivers in the Netherlands and the United Kingdom to be more beneficial than virtual visits (Giebel et al., 2023). In-person visits in all variations were predominately conducted while residents and visitors safely wore PPE and were physically distanced. Such infection-control requirements were perceived as important but were reported to alter the quality of interaction and connection between residents and families by barring physical touch and amplifying challenges with vision, hearing, and cognition, which contributed to confusion and distress among many residents and families (Giebel et al., 2023; Saad et al., 2022; Thirsk et al., 2022). Further, our participants recommended that the use of plexiglass dividers and ventilation could enable visits indoors. The evidence about the effectiveness of physical dividers to prevent indoor transmission has been variable, however (Rooney et al., 2021). Effective air ventilation, in conjunction with other infection-control measures, has been advanced in the literature as a key means of mitigating airborne transmission of SARS-CoV-2 (Public Health Ontario, 2023).

Finally, we consider the restrictions in light of Moore's (2022) value of *public justification*, described as transparency and accountability in policy decision-making. Our participants suggested that the restrictions were unclear, changing, and variably enforced. Communication from the residence administration was further described as unsatisfactory and fueled discontent. The experience of inadequate communication was similarly reported in other long-term care homes in Ontario (Siu et al., 2020). Our participants additionally observed a lack of specificity and clarity in directives from the Ministry, which gave way to differential interpretations across homes.

Participants in our study echoed findings from other studies to suggest significant discrepancies in care related to whether the care home operated for profit (Bach-Mortensen et al., 2021). While both for-profit and not-for-profit long-term care homes receive government funding as well as co-payments from residents, there is an assumption that in for-profit homes, some funding is diverted for profit, leaving less for care purposes (Pue et al., 2021). Differences described by participants aligned with published information reporting differences in rates of infections and deaths between private for-profit and government-operated care homes (Bach-Mortensen et al., 2021; Pue et al., 2021; Stall et al., 2020). This evidence suggests that the value of *public justification* was infringed and raises questions about to *whom* care homes are accountable, if not to the residents.

Establishing and enforcing quality care practices through standards and regulations could better align care with Moore's (2022) proposed public health values and improve how residents' and families' needs are met. The recently published national standards (Health Standards Ontario [HSO], 2023) guide the establishment and maintenance of safe and healthy conditions for residents to live and for staff to provide 'evidence-informed, resident-centred high-quality care that is culturally safe and trauma-informed' through which values of 'compassion, respect, dignity, trust and meaningful quality of life' (p. VI) are promoted to meet residents' goals, needs and preferences. These aims were severely challenged during the COVID-19 pandemic. Most recommendations by participants in this study are addressed by these standards, including the focus on ensuring a safe and supportive work environment for staff. The recommendation for more specific language to minimize differing interpretations by individual homes, however, may not be possible in these standards, given the breadth of the standards and the intent for them to be applied in different circumstances across the country. At the provincial level, the Ontario Fixing Long-Term Care Act and Regulation 246/22, effective as of April 11, 2022, include directives for homes to have enhanced emergency plans, defined caregiver policies ensuring access even during outbreaks, and expanded and clarified roles for infection prevention and control (O. Reg. 246/22, 2022). However, as with the standards (HSO, 2023), the language in the regulation remains vague and open to different interpretations. For example, O. Reg. 246/22 (2022) consists of an updated definition of the terms 'caregiver' and essential visitor' (section 4), with explicit stipulation that such individuals must 'continue to have access to the long-term care home during an outbreak of a communicable disease, an outbreak of a disease of public health significance, an epidemic or a pandemic, subject to any applicable laws' (section 267). What qualifies as 'access', how 'access' can be enabled, and what other impositions might be applied are not described. Another important critique is that no resources are identified for the implementation of what is mandated despite the additional funding required to develop and realize what is included in the act and regulation.

The application of an ethics framework such as Moore's (2022) has the potential to promote in-depth consideration of reasons for and implications of specific actions in responses to public health emergencies. In adhering to public health ethics, measures, including visitor restrictions, must be designed to: (a) be optimally effective and necessary, in alignment with current evidence; (b) minimize infringement of moral considerations and duties of all; and (c) not cause inequities among some sectors of the population, particularly those already marginalized by various systemic conditions. Overall, implementing infection-control measures to enable safe visiting seems to meet the criteria of *effectiveness*, *proportionality,* and *least infringement*, and should be backed by government directives with adequate funding for equipment, training, implementation, and monitoring. Based on values of *proportionality* and *necessity*, unless movement is severely restricted in other sectors of society, long-term care and retirement homes should not limit resident access to family members. Residents' rights to safe movement and visiting should be guaranteed and enforced through direct guidance to and oversight of care homes, according to the value of *public justification.*

Essential in designing and implementing long-term care and retirement home policies is engagement with the residents, family caregivers, and staff most impacted by such policies. In

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our study, resident, family, and staff participants expressed interest in participating in the design of public health measures. Siu et al. (2020) also emphasized the value of involving these stakeholders in the planning for future pandemics. It is imperative that structures and processes be implemented to ensure that these groups' experiences are integrated into policies, especially as the province and nation proceed with legislation to improve health and quality of life in long-term care. Such engagement was extensive in the creation of the National Standards for Long-Term Care (HSO, 2023); it is not clear, however, that such engagement was or will be conducted in future refinements of the Ontario Fixing Long-Term Care Act (O. Reg. 246/22, 2022). Additionally, as discussed above, it must be highlighted that expectations and governance of retirement homes differ significantly from that of long-term care. While restrictions were implemented in similar ways in both settings, new standards and policies have been enacted in relation to long-term care but not the retirement home sector. It may be assumed that retirement homes policies will align with long-term care homes, but there are no assurances of such yet. Moreover, much of the existing research has been focused on long-term care rather than retirement home contexts. Given the similarities but significant differences between the contexts, as well as the growing popularity and use of retirement homes, research in the retirement home context is urgently required.

In sum, visitor restrictions 'have come at a terrible cost, especially for marginalized communities, who have, and will continue to, disproportionately experience the hardships of the pandemic' (Moore, 2022, p. 74). Residents of long-term care and retirement homes proved to be one such marginalized group, largely represented by older adults with complex needs and vulnerabilities, living at the intersection of ageism and other systems of oppression. Visitor restrictions have exacted a heavy toll on the lives of older adults and their families. At best, movement restriction policies could be seen as efforts to limit spread as much as possible within a system with limited resources. At worst, they could be seen as a general reflection of our society's dehumanization of older adults in care homes (Faghanipour et al., 2020; Tremain, 2021). There is an urgent need for sustainable investment in the long-term care and retirement home sector to ensure effective infection control measures while not unduly restricting resident and family movement, as well as to enhance staff working conditions.

Strengths and limitations

This study captured the perspectives of resident, family, and staff participants over the course of approximately two years of the pandemic, reflecting the evolution of knowledge and policy involving long-term care and retirement home settings. We gathered a vast array of experiences over time; however, the unique circumstances of experiences often precluded direct comparisons. Each participant's experience was processed in the context of the specific timepoint in the pandemic the interview occurred, as well as the specific public guidelines in place at that time and geographic location. It is acknowledged that participants included were more likely to be able, inclined, and willing to share their perspectives; specifically, our resident participants may have had better communication and cognitive abilities than many long-term care and retirement home residents, and our family participants may have had more resources allowing them the time to participate. This may pose limits to the transferability of our results.

Further, while the policies and restrictions applied in all types of homes discussed in this article and experiences were similar, we did not have access to specific home-based policies. We also did not differentiate between participants who were talking about experiences with long-term care or retirement homes, or with for-profit, not-for-profit, or government-operated homes. A more in-depth look at differences between the types of homes would have been helpful.

Our recruitment strategy was effective for including family members, but less so for residents and staff. Unfortunately, there may have been potentially interested persons who were missed for various reasons, including limitations of social media recruitment. Additional research should be carried out with residents to get a more in-depth view of their experiences and their recommendations regarding future pandemic procedures.

Conclusion

Older adults living in care homes continue to be at high risk for COVID-related mortality and morbidity. It is now clear that visitor and movement restrictions, major tools in limiting spread, are also harmful to both residents and families. Through their lived experience, our participants – residents, family members and staff in long-term care and retirement homes – provided valuable insights for the development of more resident-centred, humane policy. Policymakers are urged to include stakeholders in the development of effective, equitable and transparent policies along with the resources to enact these, without remit to the heavy-handed strategy of visitor and movement restrictions.

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