



Safe visiting at care homes during COVID-19: A review of international guidelines and emerging practices during the COVID-19 pandemic

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Recommendations

- 1. Blanket visitor and family caregiver bans should not be used to prevent COVID-19 infections in care homes**
- 2. Safe on-site visiting practices should be used, with options chosen based on local levels of community transmission and in discussion with residents, families and staff and health authorities**
- 3. 'Family caregivers' should be designated as essential partners in a resident's care during the pandemic and be able to have more frequent, longer hands-on visits if they can be supported to do so safely**
- 4. Care homes should receive additional government funding and support to implement safe visiting practices**
- 5. Regulators should be ensuring that care homes meet residents' rights to have visitors and that safe visiting practices are being used**

1. Key findings:

- In response to rising community transmission of COVID-19 and a growing number of care home outbreaks with rapid spread and high mortality, governments and care homes across the world enacted blanket bans on visitors early in the pandemic.
- Accumulating evidence shows that visitor bans severely negatively impacted the mood and behaviour of residents resulting in a significant increase in psychotropic medication use. Evidence also suggests that bans increased feelings of guilt, fear, worry and isolation in residents' families.
- Visitor bans likely contributed to reported increases in staff workload, stress and burnout. Many regular family visitors who were providing unpaid, essential care to care home residents before the pandemic were now unable to. Additionally, managing safe visits takes additional time and resources.
- When care homes were allowed by governments to reopen to visitors, there was variability in the level of COVID-19 community transmission at reopening and safe visiting requirements (e.g. indoor or outdoor visits, frequency, number of visitors allowed). The responsibility for safe reopening was usually placed on care homes, with authorities not always providing support around implementation of safe visiting procedures (e.g. provision of additional personal protective equipment (PPE), availability and speed of testing).
- With the exception of the Netherlands, countries have not mandated that care homes reopen to visitors.
- Some visitor guidelines distinguish between general visitors who visit primarily for social reasons and family caregivers who undertake essential unpaid caregiving tasks; guidelines designated that

'family caregivers' may be allowed to visit when general social visitors are not, permitted more frequent and/or longer visits and may be able to provide hands-on care.

- Minimal research has been conducted on visitor-introduced transmission, however, the available data suggests reopening care homes to visitors and family caregivers using safe visiting practices does not lead to COVID-19 infections when community transmission levels are low. There is a small increased risk of COVID-19 entering a home, particularly when community transmission levels are higher, and safe visiting practices are not followed.
- Governments allowed care homes to reopen to visitors in when there was a large range in local levels of community transmission, there is no consensus on how low community transmission needs to be for safe visiting.
- Safe visiting practices include: conducting outdoor visits where possible, indoor visits should be in well ventilated separate areas, infection control procedures should be followed (hand hygiene, wearing of masks, cleaning), visits should be booked ahead, visitors are screened on entry, limiting the number, frequency and length of visits, and visits supervised by staff.

2. Introduction

In developed countries, about 2-7% of older people live in care homes. A typical care home resident is in their eighth decade of life, often lives with dementia and/ or multiple chronic diseases and requires significant help with their activities of daily living (Gordon, Franklin et al. 2014, Department of Economic and Social Affairs - Population Division 2017, Canadian Institute for Health Information 2018).

Care homes are group residences where personal care and accommodation are provided for older persons who need help with daily living. In different countries, care homes are called nursing homes, long-term care homes and residential aged care facilities. We define visits as two-way interactions between residents and family members and friends who are not paid care home staff. Visitor restrictions refer to constraints on the number, length, location, who can visit (e.g. by age or where they have been) and other limitations on visiting. Visitor bans are an extreme restriction which completely prohibits on-site visits, or only allows visits under compassionate grounds such as end-of-life. The COVID-19 pandemic resulted in wide scale restrictions for care homes with lockdowns that included complete visitor bans preventing residents from leaving the facility except for essential medical treatment. This is unprecedented and converse to the usual operations of care homes.

This document seeks to produce evidence-based recommendations to inform care homes and government policies on visiting in care homes during this and future pandemics. It includes a narrative review of international policy and practices relating to visitors to care homes during the COVID-19 pandemic and the impact of restrictions on residents, caregivers and staff, as well as illustrative case studies. At time of writing, ten months into the COVID-19 pandemic, many countries are experiencing increases in infections termed 'second waves' and 'third waves', care homes continue to have COVID-19 outbreaks and visitor bans have been re-instated in some regions. Care home residents and staff are being prioritised for COVID-19 vaccination, however, reducing risk of COVID-19 infection for residents will continue to be an important public health issue.

3. Minimising COVID-19 risk is rational behind visitor restriction policies

Early in 2020 little was known about COVID-19 and governments and care homes were not prepared to prevent infection and spread. The priority in early government policies related to visitors and care homes was minimising the risk of COVID-19 outbreaks. In March and April 2020 governments across the world introduced compulsory and blanket visitor bans policies stopping entry to care homes by family caregivers, families and friends, volunteers and some professionals such as podiatrists, hairdressers and entertainers (Chen, Ryskina et al. 2020, Nies, Zielman et al. 2020, Song, Kim et al. 2020). In most countries or regions, family visits were only allowed under compassionate grounds such as end-of-life, and in some countries such as Norway even end-of-life visitors were not allowed (Nies, Zielman et al. 2020). Even Sweden, known for implementing minimal COVID-19 societal restrictions with schools, workplaces, restaurants and entertainment venues staying open, implemented care home visitor bans on the 31st March 2020 (Kavaliunas, Ocaya et al. 2020).

Early care home outbreaks showed much higher risk of COVID-19 infection and mortality for care home residents than in the community (Hardy, Dubourg et al. 2020, McMichael, Currie et al. 2020), see Case Study 1. In April 2020 an estimated 46% (range 19%-80%) of all COVID-19 deaths in 21 countries were in care homes residents (Canadian Institute for Health Information 2020, Comas-Herrera, Zalakain et al. 2020). The increased risk of mortality is partly due to residents being older, having multiple co-morbidity including dementia, (Docherty, Harrison et al. 2020, Zuin, Guasti et al. 2020).

Case Study 1: A North German Care Home

By Ramona Backhaus & Hilde Verbeek

There are 14,500 German care homes where 800,000 residents live. In the first months of the pandemic, many infections were in the Southern and Western regions of Germany, with the Northern and Eastern regions less affected (Grund, Gosch et al. 2020).

The ‘Horror nursing home’

Early in the pandemic, 112 out of 160 residents of one German care home for people with dementia were infected with COVID-19. Out of these 112 residents, 47 died. In addition, many staff members were infected.

The media called this care home ‘the horror nursing home’. On the 13th March 2020, the care home was closed to visitors. According to the Chief Executive Officer, it was impossible to stop the virus from spreading to other residents and staff, even though strict measures (e.g., visitor ban, testing) were taken. It was hard to obtain sufficient PPE, many infected residents were asymptomatic and it was impossible to spatially distance residents with dementia: *‘They do not understand the concept of 1.5 meters distance. In addition, they have an urge to move around. We cannot explain to them why they should stay in their room.’*

‘I don’t even know how he died’

Because of the visitor ban, most residents died without seeing their family members and family members were not able to say goodbye. For most family members, the process of grief was hampered by not being with their loved one during the end-of-life period.

4. Visitor Restrictions and Bans

Across the world, government-imposed visitor restrictions were usually mandated under emergency or public health orders, with listed consequences such as fines or loss of licenses if policies were not followed, though the authors are not aware of any penalties being applied in relation to visitor restrictions.

Care homes and COVID-19 measures often fall under the purview of multiple levels of government (e.g. federal, state, provinces, municipalities) within the one country, multiple government departments (e.g. health, social services or a mixture of both) and different advisory and professional groups (e.g. infectious diseases, geriatrics, aged care). Each of these levels and branches of government and groups have different powers and sometimes provided inconsistent or contradictory advice.

A survey found that in England many care homes introduced visitor bans down by the 5th of February (irrespective of symptoms), and all were closed to visitors by the 30th of March (Rajan, Comas-Herrera et al. 2020) when the first visitor guidance was released by the British was first issued 8th April (Devi, Hinsliff-Smith et al. 2020). There were inconsistencies between UK government guidance, and care association policies, and care home protocols (e.g. Care Provider Alliance 2020).

Case Study 2 illustrates how a range of COVID-19 policies impacted caregiver and resident experiences of care home visits in South Australia.

Case Study 2: South Australia

By Briony Dow

South Australia has a population of 1.7 million people. Infections peaked on 26th March 2020 with 38 cases, and at time of writing (23rd December 2020) has had 566 cases in total, with the majority being overseas travellers in hotel quarantine. There have been no COVID-19 outbreaks in South Australian care homes to date.

Visitor restrictions - a caregiver's perspective

On the 18th March 2020, the Federal (national) Government declared a human biosecurity emergency and issued directives that allowed but restricted visitors to care homes, these were enforceable through fines for individuals and organisations. These directives were implemented by the care home my mother lives in.

- Visits limited to one visit per day, with a maximum of two visitors per visit
- Visits to take place in resident's room, or in outdoor areas
- Visits to be kept brief
- Children aged 16 and under are discouraged from visiting
- Do not visit if sick or have respiratory problems
- Do not visit if have not had influenza vaccine

On 26th March, we received a letter from the CEO of the facility. *"From this time (Fri 27th March) no visitors will be allowed to enter any (name of chain) home unless in exceptional circumstances."* As a family member, I could not visit my mother at all. This letter felt like it was punishing families for previous wrongdoing, it stated *"Over the week it has become apparent that our initial partial restrictions are not managing the risk of infection spread. Some visitors have been unwilling to comply with our requests and at times have been disrespectful and abusive to staff..."*

The facility visitor ban pre-dated and was more stringent than 10th April restrictions. South Australian state government formal direction under the Emergency Management Act 2004 was to limit visitor entry into residential aged care facilities (<https://www.covid-19.sa.gov.au/emergency-declarations/aged-care>). The South Australian directives limited family visits to a single visit per resident per day, plus an additional visit for care and support.

My Mum's care home banned family visits until 4th May, after which restricted family visits were permitted consistent with the South Australian government directions.

At this point, South Australia had closed its border to Victoria, where I live. I obtained an exemption to visit South Australia, a letter from my mother's GP stating that she had no other family available to visit her, and proof of a negative COVID-19 test. I drove 8-hours from Melbourne, Victoria to Adelaide, South Australia. I was stopped by police at the state border but allowed to proceed, they issued me a pass allowing me to enter South Australia and gave me an exemption from 14-day self-quarantine.

I was able to visit my Mum after three months of restrictions. My Mum was especially glad to see me and it was good to visit every day for a fortnight. All visitors were screened upon entry in compliance with SA Government directions. The care home imposed additional requirements that only 20 visitors were allowed in the facility at any one time; each visit was for a maximum of 30 minutes; visitors were to go to the person's room only; maintain physical distancing; sanitise hands on entry to the facility; not use the resident's bathroom; and residents were not allowed to leave the facility.

A second COVID-19 wave in Melbourne, and a small outbreak of community transmissions in South Australia meant that I was not able to visit again before my Mum passed away on 21st November.

5. Having onsite visitors using safe visiting practices might slightly increase risk of COVID-19 infection entering a care home

There is minimal data on how many care home COVID-19 infections are brought in by visitors when safe visiting practices are in place (these are reviewed below). Our rapid review of the literature found no scientific evidence that visitors to care homes introduced COVID-19 infections, however, during the peak of the pandemic most countries did not allow visiting. Governments have not been reporting the source of care home infections (i.e. from staff, from residents returning from hospital or from the community, from other external professionals or from visitors). There were anecdotal reports attributing infections to visitors before restrictions were introduced (Canadian Agency for Drugs and Technologies in Health (CADTH) 2020, Comas-Herrera, Salcher-Konrad et al. 2020, The National Collaborating Centre for Methods and Tools 2020). Additionally, long-term care associations in Ontario, Canada have noted that during their second wave that began in September, 2020 homes have been reporting outbreaks linked to visitors, where asymptomatic spread or breaches in safe visiting policies and PPE use occurred.

Two papers from the Netherlands and Hong Kong suggest that when community transmission of COVID-19 is low, visitors do not introduce COVID-19 infections to care homes. Netherland's pilot implementation of guidelines for opening to visitors in 26 care homes for 4 weeks from May to early June found no new infections were reported during this time in those facilities (Verbeek, Gerritsen et al. 2020). Visits were indoors, often in the residents' own room, and some care homes had a designated room for visits. Care home compliance with local visitor guidelines was judged by researchers as sufficient to good. Masks were worn except when impractical to do so (e.g. sharing coffee or food) and some care homes allowed physical contact (e.g. hugs). There was varying levels of supervision in terms of staff presence or observation during visits (Verbeek, Gerritsen et al. 2020). An expert report said that reintroducing visitors into Hong Kong care homes also did not result in infections (Chow 2020).

6. Visitors restrictions have had a negative impact on resident, family and staff wellbeing

6.1. Impact on residents

Pre-COVID-19, people living in care homes commonly had symptoms of depression (reported as between 27% and 50%) and said they felt lonely (reported as between 35% and 40%) (Australian Institute of Health and Welfare 2013, Jansson, Muurinen et al. 2017, Hoben, Heninger et al. 2019, Trybusińska and Saracen 2019). Between 50% and 90% of residents have cognitive impairment or dementia (Magaziner, German et al. 2000, Australian Institute of Health and Welfare 2012, Helvik, Engedal et al. 2015). Hence, it could be argued that residents might have less cognitive capacity and/or psychological resilience to comprehend or cope with COVID-19 changes including the fear of COVID-19 infection, experiencing negative mental health impacts of required physical distancing and lockdowns. Further, care homes may have limited access to technology (Siette, Wuthrich et al. 2020), and residents may have varying comfort with, and acceptance of, technology for communication. This means that for many resident's compensation using technology for needed and desired socialization was not possible or effective.

Several studies have shown the negative impacts of visitor restrictions and bans on resident wellbeing including increases in loneliness and behavioral symptoms. A survey of 193 residents of Dutch care homes 6-10 weeks after visitor bans found that 50% of residents reported themselves as moderately, 16% as strongly, and 11% as very strongly lonely. More than half of the 811 staff reported an increase in

severity of agitation, depression, anxiety, and irritability in residents (Van der Roest, Prins et al.). In another Dutch survey relatives (n = 1997) were concerned about increased loneliness (76%), sadness (66%) and decreased quality of life (62%) in residents (Wammes, Kolk et al. 2020). A mixed methods Dutch study that surveyed 323 care home practitioners (psychologists, elderly care physicians, nurse practitioners) and interviewed 16 practitioners, participants reported more increases than decreases in challenging behavior among residents (Leontjevas, Knippenberg et al. 2020). Almost half (48%) of family visitors in Ireland (n = 225) who were surveyed reported that their resident was not coping well with restrictions, and half said their resident had reductions in mood, activities of daily living and memory during the restrictions (O’Caoimh, O’Donovan et al. 2020).

Consistent with these increases in mood and behavioral symptoms are reports of increase in psychotropic use. In England, increased antipsychotic prescribing by about 5% has been reported for people with Alzheimer’s disease in March, April and May 2020 compared to the same months in 2018 and 2019, though these data are not exclusive to care home residents (Howard, Burns et al. 2020). A population-based study of Ontario care home residents, reported increased prescribing of psychotropic drugs out of proportion to expected trends at the onset of the COVID-19 pandemic that persisted through September 2020 (Stall, Zipursky et al. 2020).

6.2. Impact on families

Studies have shown the negative impact of bans on the wellbeing of visitors. Qualitative interviews with 10 relatives of residents in two Malaysian care homes found that the visitor ban negatively impacted relatives because they lost caregiving roles and were isolated from their loved ones (Chee 2020). Interviews with 156 Taiwanese relatives of care homes residents found they were concerned about the residents’ psychological stress (38.5%), nursing care (26.9%) and daily activity (21.1%), nevertheless 85% of those interviewed accepted the visitor restrictions (Yeh, Huang et al. 2020). Dutch relatives of care home residents (n = 1997) reported personal sadness (73%) and fear (26%) and were more satisfied when they had multiple opportunities to stay in contact with residents (Wammes, Kolk et al. 2020). Thirty eight percent of Irish visitors (n = 225) said that COVID-19 restrictions had impaired communication with care home staff and 44% experienced low psychosocial and emotional well-being (O’Caoimh, O’Donovan et al. 2020). See Case Studies 2, 3 and 4 for illustrations of impact on families.

6.3. Impact on staff

In the UK, it has been reported that staff experienced increased workloads in providing care and emotional support that banned caregivers had previously provided (Spilsbury, Devi et al. 2020). In addition staff had the additional work of communicating with families on how residents were doing (Bern-Klug and Beaulieu 2020) and facilitate telephone and videocall visits. Further, volunteers were not allowed to enter the care home which also increased staff workload as they needed to complete tasks usually undertaken by volunteers (e.g. walking outside, assisting with eating, socialisation).

Dutch elderly care physicians (n = 76) were asked about dilemmas they experienced because of visitor restrictions. The physicians talked about the profound emotional impact of visitor restrictions on themselves, the need to balance safety and quality of life and the challenge of assessing when someone was dying and how to allow that person to have visitors (Sizoo, Monnier et al. 2020). A Dutch survey of 323 care home practitioners (psychologists, elderly care physicians, nurse practitioners) found that half reported increased work load and decreased work satisfaction during restrictions (Leontjevas, Knippenberg et al. 2020). An American survey of care home staff (n = 152) found they experienced increased workloads and burnout, and were concerned about the impact of social distancing and isolation on residents particularly those missing visitors (White, Wetle et al. 2021). While a survey of

Northern Italian residential care home staff (n =1071) found that 22% reported moderate-to-severe symptoms of anxiety and 40% reported post-traumatic stress disorder symptoms (Riello, Purgato et al. 2020).

In some of the above studies (Leontjevas, Knippenberg et al. 2020, Riello, Purgato et al. 2020, White, Wetle et al. 2021) it was not possible to distinguish between the overall impact of COVID-19 pandemic and the impact of visitor restrictions on staff.

Case Study 3: Southern Dutch Nursing Home

by Ramona Backhaus & Hilde Verbeek

In 2019, about 115.000 people lived in care homes in the Netherlands. Most recent estimations from resident files (November 17, 2020) indicate that 19,254 residents had suspected Covid-19. Of these, 2,527 (13%) have died and 3,733 (19%) have recovered.

On the 20th March 2020, visitors were banned from all Dutch care homes. Residents were not allowed to leave and family, informal caregivers or friends were not allowed to enter. Eight weeks later, on May 11th 2020, the Dutch Ministry of Health, Welfare and Sports started a pilot in which 26 care homes allowed visitors to re-enter. Under very strict conditions, residents in these homes could see one visitor per week for one hour. Based on this pilot, the Dutch ministry decided all care homes without any COVID-19 cases were able to welcome one visitor per resident from May 25th 2020.

The Southern Dutch care home

This care home provides care for residents with dementia or somatic diseases. In total, 78 residents live there on eight wards. Eighty-six staff work in the care home supervised by two managers. To date no COVID-19 infections had occurred in the home. The nursing home participated in the visitor reopening pilot.

Impact on residents, family and staff

When the care home opened for visitors, the feelings of staff members were mixed. On the one hand, they were happy that residents and their families could see each other. On the other hand, they were afraid of 'opening the doors' to COVID-19. "It's great for our residents and for their family, but I am a bit afraid that having visitors leads to an infection of residents."

Staff felt that re-opening the home had a positive impact on most residents. Most family members followed the safe visiting guidelines (e.g. 1.5 meters distance to residents of staff, wearing a mask). The joy of being able to visit their relatives helped them to accept the restrictions. Seeing their relatives again led to positive emotional reactions in many family members and residents.

However, some family members of residents with dementia found it difficult to connect with their relatives, as the PPE and the distance (no hugging, no holding hands) required another way of communicating. In October 2020, managers said that in one ward staff had difficulties with family members who did not believe it was necessary to continue with safe visiting practices.

7. Resident well-being and rights were secondary consideration during lockdowns

The potentially detrimental impact of stay-at-home restrictions on mental health was recognised early in the pandemic. This has since been substantiated through research demonstrated the negative impact of stay-at-home restrictions on mental health for the community dwelling population (Ammar, Trabelsi et al. 2020, Chen, Gao et al. 2020, Killgore, Cloonan et al. 2020, Smith, Jacob et al. 2020). Despite this, supporting the wellbeing of residents was a minimally secondary consideration in visitor restriction policies or not mentioned at all. There has been academic criticism that visitor restrictions have been more stringent than they needed to be given the negative impacts on residents and lack of data showing that banning visitors prevents COVID-19 infections (Abbasi 2020, Andrews 2020).

7.1. Resident rights

Care home residents have the fundamental human right to the enjoyment of the highest attainable standard of health (World Health Organisation 2017). This includes maintaining their psychological health through connections to family and friends, and to have visitors of their choosing. Visitor guidance documents frequently were silent on the rights of residents including the rights of family to visit their loved ones. Those that mentioned resident rights suggested these need to be upheld, while in the same document contradicting this statement by condoning visitor bans and not offering concrete advice on how to ethically balance rights and risk. We agree with the argument that visitor bans superseded and contravened residents' basic rights (Kusmaul 2020).

For instance, the UK guidance states that “All decisions should be taken in light of Department of Public Health’s and care providers’ general legal obligations, such as those under the Equality Act 2010 and Human Rights Act 1998”. The same document also states that visitor bans should be in place in regions with a high COVID-19 alert level except for exceptional circumstances (Department of Health and Social Care 2020). If a service that is fully or partly funded by the local authority or National Health Service stops a resident from receiving visitors, this may be a breach of the resident’s rights under Article 8 of the European Convention on Human Rights, incorporated into the Human Rights Act 1998 (this is everyone’s right to respect for their private and family life, home and correspondence). A UK judicial review has been proposed against visitor policies because the guidance does not take into account human rights and the importance of family members to resident wellbeing and happiness (Rimmer 2020).

In the Netherlands, new legislation mandates that care homes allow visitors during the COVID-19 pandemic, irrespective of the level of community transmission and even if they have COVID-19 infections within the home. Care homes have been managing this by transferring residents to COVID-19 wards or banning visitors from specific wards where COVID-19 has been detected but not the full home.

7.2. A person-centred approach means the resident’s opinion matters

We have previously argued that if long-term care is resident-centred and caregiver-partnered then residents must have the sole authority and autonomy to decide who is/are essential in supporting their care (Stall, Johnstone et al. 2020). Further, we have argued that person-centred visitor policies should be flexible and compassionate rather than prioritising care home efficiency (Stall, Johnstone et al. 2020). We have anecdotal examples where care homes conducted a survey of residents around visitor restrictions and the residents agreed to those restrictions, however this was not commonplace. Further it is not clear whether residents were re-surveyed over time to see if their preferences remained.

7.3. Family caregivers are essential to resident care

Family caregivers are frequently an important source of emotional and practical support for care home residents (Hado and Friss Feinberg 2020). They often help residents with daily tasks such as eating grooming and recreation (Gaugler 2005, Port, Zimmerman et al. 2005) and are important in supporting the management of behavioural changes associated with dementia (Arai, Khaltar et al. 2020). Families often notice changes in health of residents and advocate for their loved ones to care home staff (Powell, Blighe et al. 2018).

In some visitor policies all visits were defined as non-essential in alignment with the unpaid nature of the caring role (e.g. by early Centres for Disease Control and Australian federal and state policies). It has been argued that classifying all visitors in this way rather than recognising their work as essential care partners overlooks their contributions (Kemp 2020). Some family caregivers would fit the definition of essential workers as they aid with activities of daily living such as feeding, grooming, and critical emotional support. See Case Study 4 – UK for example of visitors undertaken essential caregiving duties.

Other visitor policies (often those developed later or updated) recognised that visitors were essential for daily care and resident wellbeing. Designated ‘family caregivers’ were permitted to visits when general social visitors were not and had greater access when visiting (e.g. were able to visit for longer, more often, in the resident’s room or with less staff supervision). Family caregivers were sometimes required to undertake more stringent training and follow infection control protocols. For example, in the United States, Minnesota, Indiana, Florida and South Dakota allow for access or greater access for “essential caregiving” or “visits that support residents' daily living activities”. Scotland allowed visitors for ‘residents who were experiencing distress’. Individual care homes also recognised the role of family caregivers and permitted their visits (e.g. Schlaudecker 2020).

Case Study 4: UK

by Kathryn Hinsliff-Smith

In the UK around 450,000 people live in care homes.

COVID-19 in the UK

- On 23rd March 2020, the UK population were asked to “*stay at home, protect the NHS, save lives*” this included stopping visits to care home residents.
- On the 13th April there were 92 UK care homes with one or more COVID-19 positive residents. The same day that the UK hospital death rate was 11,329.
- After the first lockdown, each of the nations in the UK made independent decisions. 5th November, England enters a 2nd lockdown. New guidance on visiting care homes states that ‘Maintaining some opportunities for visiting to take place is critical’. Care home providers must work with families and local professionals to make decisions about visiting policy, carrying out a risk assessment based on local transmission of COVID-19 and other factors, e.g. whether the physical layout of the care home in question allows for social distancing. If a care home experiences an outbreak, it must restrict visiting to end of life.
- Guidance sets out principles to support safe visiting including: limiting visitor numbers to an absolute maximum of 2 constant visitors per resident; ensuring PPE is used; maintaining social distancing; and arranging bookings for visits. Guidance states that *‘visits should happen in the open air*

wherever possible' or in a dedicated room if this is not possible. Other options include using a 'substantial (e.g. floor to ceiling) screen between the resident or visitor' or 'temporary outdoor structures – sometimes referred to as 'visiting pods – which are enclosed to some degree but are still outside the main building of the home'.

Relatives' experience

These cases are drawn from a UK study of regular visitors to a care home. These two relatives visit different care homes.

Amy

Amy visited her 96-year-old mother every day since she was admitted to a care home in 2016. Amy would visit every afternoon and stay for 3 - 4 hours. Each visit would consist of some activity (doing a crossword, reading a book), as well as assisting her mother eat her evening meal. Amy would leave once her mother was settled in her room for the night. Amy felt she had good a good relationship with the staff.

Initially Amy was accepting that the safety of her mother and other relatives was very important and to reduce the risk she was not able to visit at all. However, after months Amy wanted to be able to visit. By this time her mother received a terminal diagnosis and was totally bedbound. Amy realised that her mother was going to pass away, and that that there had been 12 COVID-19 deaths in the home *"it seemed totally unfair when in the UK others were free to visit restaurants and pubs but I can't visit my mother inside"*.

Amy wanted to bring her mother to her own house and care for her but encountered a 30-day notice period - *"another obstacle"*. Due to end-of-life Amy was granted access to visit the home for extended periods after a negative COVID test. Amy's mother passed away from cancer in September *"whilst it seems inhumane not to see my dying mother sooner in the lockdown period, this will live with me forever"*.

Elizabeth

Elizabeth has been married to Joe for over 30 years. Joe was diagnosed with Alzheimer's when aged 64 in 2012. In 2016 he moved into a local care home. Joe is now non-verbal and deaf, doubly incontinent and not able to walk. Elizabeth visited Jo nearly every day and would stay for between 2 – 4 hours. Elizabeth was *"devasted"* when no visits were allowed as she performed most of Joe's personal care and grooming including trimming his beard. She said *"me and Joe were always a very tactile couple and although he couldn't speak we chatted for hours"*. A staff carer kept in touch with Elizabeth and initiated a WhatsApp call nearly every day for a few minutes. On the 8th July Elizabeth made her first window visit to Joe, *"it was very emotional and whilst it was a one-way conversation, it was wonderful"*. However, at the 2nd and 3rd window visit Elizabeth expressed that she *"felt flat"*. During the next few months window visit protocols appeared to change from closed windows, to open windows then to open doors and on one visit Elizabeth was shocked to see that Joe's beard had been removed: *"he had a beard for years, a new carer took it upon herself to shave him, I was devastated"*.

Elizabeth is still having window visits in November and is not sure what is planned once winter weather prevents this. *"It shouldn't be a blanket ban on everyone, I regularly came to see my husband, I am not a visitor but an essential part of his care"*.

8. Easing and restarting visitor restrictions

As COVID-19 community transmission fell after the first wave and with community restrictions easing, visitors were allowed into care homes in many regions. Some regions (e.g. UK, New Zealand) have tiers (also known as levels or stages) that describe the stringency of COVID-19 related restrictions by tier. Care home visitor restrictions are sometimes included as part of this, but this is inconsistent.

Reopening to visitors was usually not mandated by government policy. Many governments placed the responsibility on care homes on ensuring they were in the position to safely allow visitors and deciding when to reopen. For instance in the United States, the Centres for Disease April guidelines state that each state is responsible for deciding when to allow visitors and can do so across the whole state parts of the state or on an individual facility basis (Centres for Disease Control and Prevention (CDC) 2020). Reviewing US state policies (Soergel 2020), the majority leave the final decision on safe reopening to individual care homes. However there is limited US government help for facilities to obtain PPE and COVID-19 tests (Society 2020) which are requirements for safe reopening (Eyigo and Pekruhn 2020).

With repeat COVID-19 waves, visitor restrictions were re-introduced – some complete visitor bans, whereas some allowed ‘family caregivers’ to continue to visit. In Ontario, Canada general social visits were encouraged outside, and in September 2020 family caregivers were allowed inside homes for essential caregiving activities. As Ontario entered its second wave, care homes in high COVID-19 transmission areas restricted general social visits, but family caregivers could still see residents.

9. Requirements for reopening to visitors

Considerations listed in guidance documents around reopening to visitors include that the care home is COVID-19 free (various definitions of COVID-19 free), have sufficient staff, have access to PPE, availability of hospital beds if required, and availability of testing or regular testing in place for staff and residents (Malikov, Huang et al. 2020).

Many visitor guidance documents suggest that regional context should be considered when making a risk-based decision on allowing visitors. This is consistent with research showing that the prevalence of COVID-19 in the community is a strong predictor of COVID-19 infections in a care home (Gorges and Konetzka 2020, Stall, Jones et al. 2020, Sugg, Spaulding et al. 2021). Additionally, having staff who live in high COVID-19 prevalence areas also increases risk of care home infections (Shi, Bakaev et al. 2020).

We were not able to identify guidance documents specifying the COVID-19 transmission figure at which it is safe to have visitors. We selected a few regions which had reopening to visitors and examined the COVID-19 transmission in the week preceding reopening in 2020. There was a wide range of new cases per 1000 people in the week before reopening from 0 in South Australia (reopened 4th April), 0.01 Scotland (reopened 3rd July), 0.07 Netherlands (reopened 25th May), 0.11 in New York, USA (reopened 17th September), 0.34 in Sweden (reopened 1st October), 1.27 Arkansas, USA (reopened 1st July). These data suggest that there is no consistency on what COVID-19 community transmission rates are considered low enough for safe reopening. It is not clear what other factors were used to decide or influenced reopening.

10. Safe visiting practices

Visiting guidelines and policies have included the following:

- Some safe visiting guidelines/policies suggest that outdoor visits be conducted in preference to indoor visits, or outdoor visits can be held before indoor visits. There was a COVID-19 outbreak in a Dutch care home that was likely due to aerosol transmission in a setting of inadequate ventilation (De Man, Paltansing et al. 2020), this and other data on aerosol transmission suggest that outdoor visits may be safer than indoor visits. However outdoor visits are not always possible because of weather, the layout of the facility or the mobility and other characteristics of the resident or visitor. Some visiting policies suggest a staged approach allowing outdoor visits before indoor visits - for instance the Scottish guidance has stage 1 as essential visits only, stage 2 as one-visitor garden and essential visits, stage 3 one-visitor indoor visits, multiple visitor garden visits and essential visits, and stage 4 as controlled visiting. Other policies documents (e.g. Netherlands) did not use this staged approach and allowed for indoor visits upon reopening.
- Indoor visits should be well ventilated, in a separate space to where other residents are and ideally accessible by visitors without going through the rest of the facility. Bespoke buildings or rooms with glass partitions have been built by some care homes for these visits.
- All guidelines/policies state that infection control procedures should be followed during visits including hand hygiene, wearing of masks by the visitor and resident when possible, cleaning before and after visits.
- Visits should be booked ahead, preferably using an electronic system, and visitors logged when arriving and leaving.
- Most guidelines/policies suggest that visitors be screened at entry for symptoms and temperature and some policies exclude visitors from COVID-19 hotspots (hotspots are variously defined).
- Most guidelines/policies do not require visitors to show a negative COVID-19 test result. However, in Ontario, Canada with the reopening of its care homes to visitors on June 12,,2020 there has been a requirement that family caregivers must get COVID-19 tested every two weeks and in high COVID-19 incidence zones this is required weekly. This testing has been burdensome caregivers and can be a barrier to visiting. In the neighbouring province of Quebec, its government on November 5th, 2020 made it explicitly clear that care homes could not demand proof of a negative test as a requirement for a visitor to visit with a care home resident. In some German regions, rapid COVID-19 tests that can produce a result after 20 minutes are being used to test visitors at the entrance to the care home, with a negative test being required before entry.
- Guidelines/policies often include requirements that minimise the number of visitors and length or frequency of visits. These requirements are operationalised in different ways e.g. Wales states to minimise the number of households that visitors are drawn from, whereas England states there should be a single visitor per resident.
- Some guidelines/policies specify that staff should supervise visits to ensure compliance with infection control and physical distancing.
- The World Health Organisation Jan 8th guidance additionally suggests that care homes have adequate staffing available to support interaction between residents and visitors, a designated individual to educate and help visitors with infection control and prevention and a monitoring system to check visitors' compliance with infection control(World Health Organisation 2020)

A Delphi panel of 21 American and Canadian experts recommended that safe visiting should include (1) infection prevention and control precautions, (2) outdoor visits when feasible and indoor visits when not possible, (3) limited physical contact with appropriate precautions (hand hygiene, masks, gowns and

gloves), (4) assessment of individual residents' care preferences and level of risk tolerance, and (5) 'essential caregivers' designated for each resident (Bergman, Stall et al. 2020).

11. Visitor vaccinations as part of safe visiting practices

In a few places such as Germany and Ontario family caregivers have been prioritised to receive COVID-19 vaccinations. It is possible that future safe visiting policies may require proof of vaccination for care home visitors except for those for whom it is medically contra-indicated.

12. Recommendations

The COVID-19 pandemic will be an international public health issue for at least another year, it is currently unclear if the vaccines currently being rolled out will sufficiently decrease transmission. At time of writing, second COVID-19 waves and increased community restrictions are occurring throughout Europe and the Americas. In some regions (e.g. Australia, New Zealand) these community restrictions included reinstating of visitor bans or restrictions. In some parts of the UK and America visitor bans have not been lifted.

Recommendation 1 - Blanket visitor and family caregiver bans should not be used to prevent COVID-19 infections in care homes

It is often a resident's right enshrined in legislation to have visitors, there is clear evidence that ongoing visitor bans have negative consequences for residents, visitors and staff. It is possible that visitors may bring COVID-19 into facilities even with safe visiting practices, however the small additional risk should be considered against the benefits of visits. Therefore, safe on-site visiting should be required of care homes except under exceptional circumstances.

There are multiple practices with better evidence and efficacy for minimising the risk of care home infections and less evidence for negative impacts on resident and family wellbeing including during a care home outbreak (The Health Technology Assessment Unit 2020, The National Collaborating Centre for Methods and Tools 2020, World Health Organisation 2020). Care homes should be establishing surveillance and monitoring systems, mandating the use of appropriate PPE, physically distancing or cohorting residents, practicing environmental cleaning and disinfection, promoting hand and respiratory hygiene among residents, staff, and visitors and providing paid sick leave to staff (Rios, Radhakrishnan et al. 2020).

Care homes with higher quality ratings, and more care and nursing staff are associated with a lower chance of any COVID-19 infections, COVID-19 spread and deaths (Figueroa, Wadhwa et al. 2020, Gorges and Konetzka 2020, Harrington, Ross et al. 2020, He, Li et al. 2020, Li, Temkin-Greener et al. 2020, Sugg, Spaulding et al. 2021)

Care homes with newer designs that offer more single occupancy accommodation are associated with a lower risk of infections and deaths (Stall, Jones et al. 2020) while more crowded care homes have higher risk of infection (Brown, Jones et al. 2020). Homes with better ventilation may also be at reduced risk of infection (De Man, Paltansing et al. 2020)

Recommendation 2 - Safe on-site visiting practices should be used, with options chosen based on local levels of community transmission and in discussion with residents, families and staff and health authorities

Safe visiting policies should allow a more flexible approach to care home visits. Discussion with residents, families and staff around the care home policies, as well as individual resident circumstances would be a person-centred approach that also considers the risk for others in the home. Rather than total bans, policies should acknowledge the ever changing COVID-19 situation and emphasise the need for safe visiting procedures based on the level of community transmission. For instance, when there is high COVID-19 community transmission in the area having outdoor visits rather than inside visits, or limiting the number of different visitors but allowing longer or more frequent visits from the same people. We have outlined above and elsewhere safe visiting practices (Stall, Johnstone et al. 2020).

Recommendation 3 - ‘Family caregivers’ should be designated an essential partners in a resident’s care during the pandemic and be able to have more frequent, longer hands-on visits if they can be supported to do so safely.

Residents should have designated ‘family caregivers’ (i.e. visitors essential for daily care and resident wellbeing), these family caregivers may be able to visit more frequently or for longer than general social visitors. Family caregivers should be able to provide hands on care if they meet the same requirements as staff in terms of infection control training, use of PPE and COVID testing.

Recommendation 4 - Care homes should receive additional government funding and support to implement safe visiting practices

There are additional costs in implementing safe visiting practices such as setting up the booking system, setting up appropriate spaces, staff time to screen visitors, escort residents to visits and disinfect visiting spaces.

Recommendation 5 - Regulators should be ensuring that care homes meet residents’ rights to have visitors and that safe visiting practices are being used

Care homes sometimes have instituted more restrictive policies relating to visitors than government directives. We were not able to identify examples of care home regulation policies which specify how regulators are monitoring resident wellbeing and visitor related rights. Given that visitor bans and restrictions have impacted on resident wellbeing, and violate resident rights, regulators should be ensuring that care homes are supporting every resident to have visits according to their needs.

13. Conclusion

Governments across the world have consistently introduced blanket restrictions to visitors in care homes as a response to the risk of COVID19 infection. There is considerable evidence that restricting visitors, especially close family members, to care homes has detrimental effects on residents’ mental health, especially for people living with dementia. However, there is little evidence that family visitors are responsible for introducing infection into care homes, possibly because visitors have had limited access, lack of research and publicly available data. To date there has been little consideration of residents’ and families’ rights and preferences in relation to visitor restrictions. A more nuanced approach to visitation is needed, considering the level of community transmission, actual risk to residents of infection, capacity of the facility to control infection, risk to residents’ mental health and, most importantly, their rights and preferences.

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