



Ethical Implications of COVID-19

Palliative Care, Public Health, and Long-Term Care Facilities

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Outbreaks of COVID-19 among nursing homes, assisted living facilities, and other long-term care facilities in the United States have had devastating effects on residents. Restrictions such as banning visitors, sequestering residents, and testing health care staff have been implemented to mitigate the spread of the virus. However, consequences include a decline in mental and physical health, decompensation, and a sense of hopelessness among residents. We present and explore a case study at an assisted living facility addressing the ethical issues in balancing the management of the community versus the resident's right to autonomy and self-determination. A team of palliative care experts was brought into assisted living facilities to manage patients, care for well residents, and provide input in advance care planning and symptom management. The principles of self-determination and autonomy, stewardship, and distributive justice were explored. The use of nursing skills in triage and assessment, principles in public health, and the 8 domains of palliative care provided a comprehensive framework for structuring emergency operations. Palliative interventions and the role of palliative care nurses played an integral part in addressing ethical challenges in the containment of the virus and the deleterious effects of social isolation among the elderly.

including nursing homes, assisted living facilities (ALFs), and other eldercare facilities are staggering, with an estimated fatality count of 45% of all deaths. Throughout the United States, nursing home residents account for less than 8% of the population but constitute almost half of the COVID-19-related deaths, indicating that this virus has devastating effects on this vulnerable, elderly population.² States have tried to limit the spread of the virus by banning visitors, sequestering residents to their rooms, and testing health care staff. However, these residents then endure declines in mental and physical health because of isolation, decompensation, and a sense of hopelessness with the uncertainty of the future. Across the United States, LTC facilities are in various phases of restrictions and reopening, with states attempting to balance the benefits of visitation and socialization versus the spread of the virus.

PURPOSE

This article aims to discuss the ethical issues surrounding LTC facilities with positive COVID-19 cases among residents, specifically, balancing management of the community with an individual's right to autonomy and self-determination. In this case study, a team of palliative experts was brought into ALFs to manage ill residents, care for well residents, and provide input in advance care planning and symptom management.

PALLIATIVE CARE AND COVID-19

Palliative care focuses on holistic care that encompasses the mind, body, and spirit to enhance comfort and preserve dignity.³ The demand for palliative care has been highlighted during the pandemic, with increases in conversations about advance care planning, hospitalizations, and discussions on prognosis. The approach to palliative care, however, has varied slightly to mitigate the virus and preserve the wellness of the greater community. Because of COVID-19's rapid spread, person-centered care, the foundation of palliative care, could not be used exclusively. Instead, person-centered care was combined with a public health approach to treat multiple residents who became ill simultaneously.⁴

Public health nursing focuses on the health needs of an entire population by assessing the community through a comprehensive, systematic approach.⁵ The combination

KEY WORDS

palliative care, COVID-19, assisted living facilities, nursing, public health

As of December 10, 2020, the Centers for Disease Control and Prevention (CDC) has reported 15 million cases and 285 000 deaths related to COVID-19 in the United States.¹ Outbreaks in long-term care (LTC) settings

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of palliative care concepts with public health nursing provided a guide in caring for residents in LTC facilities. In attempts to mitigate a rapidly evolving and novel disease in these facilities, the focus became community first and individuals secondarily. From this lens, competing ethical principles were brought forward in decision making.

LTC FACILITIES AND COVID-19

Approximately 2.1 million older adults reside in LTC facilities in the United States.⁶ Nursing homes and ALFs are unique communities vulnerable to infections, and because of their congregate nature and characteristics of the population (ie, older adults, often with chronic underlying conditions), the risk for pathogen spread is high.⁷ COVID-19 has demonstrated how devastating this virus can be on these types of communities. In mid-March, the CDC reported that a skilled nursing facility (SNF) in King County accounted for more than 70% of all deaths in Washington State. Further analysis found widespread disease throughout the county with community transmission occurring as early as January 2020. The spread of the virus was facilitated by ill staff, a shortage of hand sanitizer and personal protective equipment, a lack of testing, and staff rotating through multiple facilities.⁸ This first outbreak was just the beginning of rampant disease spread in the United States. Facilities across the country struggled to prevent and control COVID-19 infections as the virus surged throughout the wider population. Residents' age and high levels of chronic illness made them particularly susceptible to complications and mortality from COVID-19, causing rapid deterioration of health, increased hospitalizations, and death.⁷

CASE STUDY

This case study examines an outbreak in an ALF where several residents and staff members showed respiratory symptoms commensurate with COVID-19, including fever, cough, shortness of breath, and fatigue, in March 2020. This outbreak occurred within weeks of the first case of COVID-19 in the state, before testing supplies and facilities were widely available. Considering the King County episode, additional personnel from homecare and practitioners from the community were mobilized to partner with facility staff to mitigate the outbreak among the remaining unaffected residents. Homecare staff was also charged with monitoring and treating those residents exhibiting mild infections as they sheltered in place and with triaging the more severe infections to the local emergency department.

The residents in the facility lived in individual apartments. They had been sheltering in place for 2 weeks, as mandated by the state's Department of Public Health, when the early signs of outbreak appeared. Once these

restrictions were implemented, all medications, food, and supplies were brought to residents in their apartments by staff members donning gloves and N95 masks at a minimum. Those staff who were caring for ill, symptomatic residents also had to wear gowns and face shields. Staff were assigned to care for either ill residents or well residents to avoid cross-contamination.

This case study's objective demonstrates the ethical management of residents in a communal setting during a pandemic, which requires that the rights of the individuals be considered against the need to restrict their rights to protect the greater community. Restrictions were eased or tightened based on relative risk to contain the infection while avoiding the unintended consequences of prolonged isolation.

INTERVENTION BY HOMECARE

Similar to the facility in King County, Washington, efforts to mitigate the spread of COVID-19 among eldercare facilities throughout the state were obstructed by a lack of testing materials and methods to process tests, as well as limited understanding of the rapidly emergent disease process.⁹ The organization brought in providers and homecare nurses with palliative care expertise to triage residents, manage symptoms, and monitor health patterns among residents. To determine residents' goals and provide support for symptom management, the palliative team used the National Consensus Project for Quality Palliative Care Guidelines 8 domains of palliative care.³ This provided the structure and process to systematically address the physical, psychosocial, spiritual, cultural, and ethical needs of the residents, as well as provide the specialized care of residents at the end of life. Palliative care nurses rounded on presumed positive residents along with advanced practice registered nurses (APRNs) and physicians to decide which residents should remain at the ALF and which should be hospitalized. Physical therapists and occupational therapists from homecare assessed the cognition, physical safety, and functional abilities of the residents and made recommendations, when appropriate. The hospice homecare bereavement coordinator and volunteer coordinator made daily rounds to evaluate residents' anticipatory grief and provided support to those struggling emotionally.

ETHICAL IMPLICATIONS

In the ethical management of a community population during a pandemic, a respect for self-determination must be weighed against stewardship of the community. Self-determination requires recognition that every person is an individual with singular thoughts, beliefs, and cultural practices that influence health care decision making.¹⁰ However, where the individual is an interdependent



member of a community, the right of self-determination may be limited by the welfare of others in that community. In these circumstances, the interdisciplinary team (IDT) must recognize the departure from the standard of care and ensure that lesser restrictions are prohibitive.¹¹ When the needs of the community affect individual health care decisions, the IDT must also help the individuals to understand restrictions in the broader context.

On several occasions, asymptomatic individuals expressed a desire to visit with other residents within the community. The palliative team needed to educate these residents as they attempted to leave their apartments. Because of conflicting information from various news sources, some residents were dismissive of the harsh measures the facility was taking. Furthermore, in the interest of confidentiality, the staff could only confirm the presence of the virus in the building, but not specific residents who were ill. The IDT kept residents and their families informed of the statewide Department of Public Health guidelines, along with the rationale for the strict isolation.

Stewardship in the form of preserving the less tangible benefits of communal living was also important. Assisted living facilities are largely marketed as a means of maintaining independence for elders who have increased needs due to waning health status or functional decline. Administration was mindful that isolation and sequestration subverted the aims of providing social interaction and physical activity for their residents. Having the palliative team to supplement the efforts of the remaining staff provided the extra layer of support to meet the social, emotional, and spiritual needs of the residents who were finding themselves suddenly shut off from their usual social support in a time of crisis.

A concern regarding distributive justice also emerged as the palliative team engaged the residents and their families in goals of care conversations. In the push to encourage citizens to maintain social distance to “flatten the curve” of disease incidence, media coverage often discussed the prospect of overwhelmed capacity in the community and a shortage of resources. In reviewing advance directives and discussing advance care planning, some residents questioned whether these crucial conversations in the context of a pandemic suggested that there would be rationing of resources based on the residents’ advanced age if the hospital system were to become overwhelmed. The local hospital never had to ration ventilators, equipment, or supplies; however, residents needed to be reassured that their decisions would not be used as a means of determining who would get priority care. For those residents who were symptomatic, daily conversations with the residents and telephone calls to update their family support persons were critical to demonstrate that the team was actively moderating their individual plans of care, regardless of their personal health decisions.

DISCUSSION

The imminent risks for elders with COVID-19 infections are apparent, as 80% of all deaths from the coronavirus have been in those 65 years and older.¹² However, social isolation, loss of autonomy, and restrictions in a communal setting also impose an insidious threat to the health and well-being of this population, regardless of their exposure to the virus, and therefore must be considered in the ethical management of an eldercare facility during a pandemic.

Social Isolation and Decompensation

Reports from Washington State’s initial outbreak found that residents were frustrated with isolation to their rooms, poor communication with families, and a lack of testing. As outbreaks continued to occur throughout the country, local and state governments were prompted to impose strict restrictions on visitation and socialization in eldercare facilities. Although this was necessary to attempt to halt the spread of the virus, increased isolation has been shown to impact physical and mental wellness.¹³ A review of studies on loneliness and social isolation found that actual and perceived social isolation was associated with increased risk for early mortality. After accounting for age and socioeconomic status, data from 70 studies showed that loneliness and social isolation contributed to an increased mortality rate of 26% and 29%, respectively. Specifically, adults with strong social relationships had a 50% higher likelihood of surviving a pathological insult compared with those who are isolated.¹⁴ Additional research has also connected social isolation with exacerbations of disease-related morbidity and mortality at the cellular level, including the neuroendocrine axis, the immune system, and the autonomic nervous system.¹⁵

In this case study, residents lived in private apartments with assistance from staff for medication management, personal care, wellness checks, and meal preparation. Before the pandemic, dining arrangements were communal, offering opportunities for group socialization; however, these activities were stopped, and food was delivered in individual trays to the apartments. Those who were suspected of being infected with COVID-19 had food in disposable containers discarded in a separate location. After the facility was closed to outside visitors and residents were restricted to their apartments, the effects of isolation appeared quickly among the well residents and the mild to moderately ill residents. Staff noticed a marked decline in residents’ intake. Residents reported being more forgetful, losing track of time and day, and forgetting to perform basic hygiene. Residents’ sleep cycles were disrupted, with some taking multiple naps during the day, and others going to bed or waking up earlier or later than usual. Sundowning among residents occurred more frequently,



and family members reported mood changes and cognitive decline when communicating with residents.

Autonomy and Individual Preferences

Barriers associated with goals of care conversations are well documented. They include clinicians' lack of training and comfort, available time for communication, confusion about advance care planning, and desire for aggressive treatment. Systemic barriers include an absence of societal acceptance of planning for end of life.^{16,17} During COVID-19, these challenges were magnified because of the heightened emotions precipitated by limitations on communication and inadequate information on the virus. Nevertheless, it was essential to address individuals' goals related to prolonged life support, options for quality of life, and choosing to forgo futile or unwanted treatment in a timely manner to compensate for the overburdened health systems and attempts to stop viral transmission.¹⁸

The initial goal of the intervention by homecare was to identify potential positive COVID-19 cases and determine if hospitalization was necessary and consistent with the residents' goals of care. No visitors were allowed into the facilities; therefore, hospice and palliative clinicians discussed goals of care with family and residents via telehealth. Although many residents had living wills, those goals of care decisions were not formulated in the context of a novel virus with rapid, devastating effects. The state-sponsored guide on creating a living will is based on a scenario where a person has an incurable or irreversible medical condition.¹⁹ With a novel disease process, there was no body of evidence to determine curability or reversibility. Furthermore, many conversations were initiated owing to sudden and precipitous changes in condition before diagnosis confirmation. This contributed to feelings of disbelief for family members, particularly when the resident had been in relatively good health prior to the pandemic.

The palliative care team's objective was to update each family member daily on the resident's status, noting any changes in condition. When possible, telehealth visits were arranged with family to solicit the symptomatic residents' preferences. A dedicated palliative RN was enlisted to coordinate prompt goals of care conversations, which was necessary because of the rapid deterioration of some residents once they became symptomatic. Obstacles to establishing rapport with the residents and family members under these circumstances included conducting discussions via telehealth using unfamiliar technology and balancing reassurances with a realistic perspective of the current situation. In many cases, the family did not recognize the urgency of the situation because they did not witness the change in condition. The palliative RN also coordinated discussions with the providers who visited daily to gently but quickly reframe the family's understanding of

the resident's condition to minimize the sense that these decisions were being made under duress.

Communal Living and Public Health

Communal living among the elderly has shown benefits in promoting healthy lifestyles and assisting with activities of daily living (ADLs). These communities promote safe housing, socialization, and access to wellness services. Services from ALFs, compared with SNFs and home and community-based services, have shown high quality of life outcomes. Research suggests that socialization and minimizing the effects of isolation have contributed to increased quality of life for older adults residing in ALFs.²⁰ Communal dining can also contribute to increased food intake, positive psychological and social benefits, and improved appetite through the physical change in location.²¹ The social benefits of assisted living were significantly undermined when the shelter in place and visitation restrictions were enacted.

With COVID-19, ALFs and SNFs have placed restrictions on visitors since March 2020. Experts have reflected on the importance of containment strategies but also have discussed the detrimental effects of isolation. The importance of social connectedness has been highlighted among the elderly. The need for social connectedness, either through visits by family members or caregivers, or interactions with other residents, is a human characteristic intertwined with neural, hormonal mechanisms. Social isolation has been associated with increased risk for cardiovascular, autoimmune, neurocognitive, and mental health problems, including depression and anxiety. Family and caregiver visits have also been associated with improved intake among residents, increased collaboration between family and staff, and detection of changes in condition among residents.²²

The palliative team developed a containment strategy to triage only the sickest patients who desired treatment to the hospital. Residents who were ill but relatively stable were closely monitored around the clock and with daily visits by medical providers. Two of the ill residents who had very serious preexisting comorbidities elected a hospice plan of care. All other residents were restricted to their rooms to prevent the spread of COVID-19.

This initial balance of restrictive isolation versus containment of the virus was essential. In the months that have passed, outdoor visits have been allowed while the weather has been warm and include temperature checks, mask requirements, and time limits. However, as this is written, cases of COVID-19 have started to increase in the state and complete restriction on visitation has been reinstated. Residents are allowed to leave their rooms only for short periods, and communal dining, in-person activities, and social gatherings are still restricted.



Throughout the course of the pandemic, residents have expressed frustration at being cut off from communications. Most have been acutely aware of the pandemic, as television and radio has been their primary connection to the outside world. Some have struggled with the fact that staff could not tell them which residents were ill or hospitalized because of privacy protections. Some have learned of deaths among their population from obituaries or family members who were in touch with other residents' family members. Although many of them telephoned their friends and neighbors within the community, they also expressed anxiety for community members with whom they had more casual relationships.

OUTCOMES, RECOMMENDATIONS, AND LESSONS LEARNED

The CDC has recommendations for nursing facilities that outline criteria to determine when nursing homes can relax restrictions on visitation and group activities. Their suggestions include assessing COVID-19-positive cases in the community and facility, ensuring adequate staffing is in place, providing access to testing for residents and staff, creating written screening protocols, providing access to appropriate personal protective equipment, limiting communal dining, and restricting group activities. Visitation is addressed in the final phase of reopening and includes social distancing measures, hand hygiene, and mask use.⁷

Lessons learned by the palliative care team for containment of COVID-19 at these eldercare facilities included adapting new information on the disease process, managing the new information at each phase of the intervention, and having goals of care conversations with all residents regardless of disease status.

Structure and Processes of Care

A familiarity with the first domain of palliative care allowed the Director of Palliative Services and the Executive Director of Homecare to quickly establish a frontline team consisting of nurses, aides, physical and occupational therapists, spiritual and bereavement professionals, and other hospice personnel. Although the group initially prioritized the physical concerns of those presumed to be infected with the virus, the team was quickly expanded to assess and plan for meeting physical, functional, psychological, social, spiritual, and cultural needs to the extent allowable within the confines of the restrictions. The directors were located outside of the building but were in frequent contact with the frontline staff, coordinating equipment and supply delivery and directing staff from other areas of the organization to work under the direction of the palliative nurses at the ALF.

The directors also worked closely with the facility administration and the incident command team of the

organization. Their role was also to follow, analyze, and communicate new information being generated daily from state and federal agencies on the emergent disease process. For example, at the start of the outbreak, COVID-19 was described as a respiratory illness, but within the first 2 weeks, the watch list of symptoms was expanded to include gastrointestinal symptoms and skin rashes. New information needed to be delivered to the frontline staff who could incorporate it into daily operations. The key was consistent communication with debriefings at least twice per day. External oversight and management of the supply chain and human resources freed the nurses within the facilities to develop person-centered plans of care for the ill and at-risk residents and their families.

Physical Aspects of Care

Once the sickest residents were dispatched to a higher level of care and plans were developed for surveilling and managing symptoms in those ill residents who were to remain in their apartments, attention could be directed at the potentially deleterious effects of physical confinement. Some residents were noted to always be in the same spot when staff went into their apartments to deliver or remove trays. It was also noted that some residents were not changing clothes and some residents would be found in bed frequently or at odd hours. Based on this pattern, the team brainstormed ideas for measuring and tracking baseline function and promoting activity and a "new normal" ADL routine. Physical therapists and aides were brought in to assist with ambulation, exercise, and ADLs. Several of the residents qualified for a restorative plan of care and were formally admitted to homecare. Those who were at risk for deconditioning participated in exercises in their rooms. The facilities' recreation therapists provided exercise instruction via a closed-circuit television channel.

Staff noted that many of the residents seemed to be eating much less than they typically would in their communal dining situation. Some residents were noted to have poor skin turgor, dry mucous membranes, and fatigue associated with dehydration. Staff who were familiar with the residents' baseline cognitive status also reported varying levels of forgetfulness and behavior changes. The team worked to establish an understanding of all residents' baseline cognitive and functional status by reviewing quarterly assessments in the residents' wellness records. They then developed a tool for monitoring vital signs, mental state, intake and output, and other physical and behavioral findings that would indicate a departure from baseline cognitive or functional status. These tools were posted in each resident's rooms, and all staff were instructed to report significant changes immediately. Change of shift handoff report included all team members, so that solutions to developing issues could be brainstormed in real-time.



A key factor in addressing changes from baseline mentation was interdisciplinary teamwork. For example, impediments to nutritional intake included limited meal choices; lack of staff attention; and unappealing appearance, temperature, and esthetic of eating meals delivered in styrofoam containers. The team worked with the facilities' dietary staff to provide broth and tea on each floor that would make it easy for the aides to offer these beverages between meals and at night. Some residents were identified as requiring a staff member to sit in the room to socialize with the resident during mealtimes, perhaps sipping a beverage to simulate the communal camaraderie that these residents appeared to be missing or replating the meal on the resident's own dinnerware. The staff also offered to go through the residents' refrigerators to remove food and beverages that were expired or of indeterminate age to prevent accidental ingestion of spoiled food. The team posted intake and output sheets in every room so that a marked pattern in poor intake could be identified and addressed.

Psychological, Social, Cultural, and Spiritual Aspects of Care

The team also recognized the potential for cognitive deterioration among the secluded residents. The facilities had been in the practice of administering cognitive assessments using the Montreal Cognitive Assessment tool. A nurse and an occupational therapist from the homecare program were brought in to readminister this test to all residents for comparison. Those who had experienced a decrease in scores were monitored more closely and were visited by members of the IDT, including a chaplain, a bereavement coordinator, and a volunteer coordinator. Nurses from the organization's Center for Professional Development provided activities for the residents, including pencil puzzles and art supplies.

Most of the residents welcomed these daily visits, which were unstructured and intended to give the resident a chance to discuss fears or sorrows and also to reflect on positive accomplishments and achievements. The visits also focused on residents' psychological difficulties, addressed cultural aspects of care, and responded to existential or spiritual distress. The visits by the IDT allowed residents an opportunity to discuss the source of their distress and reflect on the new and changing situation. Culturally, the IDT identified and recognized what was important to the resident, which allowed them to tailor conversations and discussions. The frontline staff were continually educated to revise their assessment criteria as new findings emerged, sometimes daily.

Care for the Imminently Dying

Care for the patient and family at the end of life was critical to provide support to the resident, families, and staff at the ALF. With uncertainty about the trajectory of illness,

detailed and comprehensive assessments were done by palliative care and ALF staff to manage symptoms and pain. In addition to the physical aspects of care, social, spiritual, and psychological needs were discussed and addressed with patients and families using all members of the IDT. This included frequent contact with family members and continuous updates on patient status. Symptom management included treatment of dyspnea, nausea, agitation and confusion, delirium, and pain. Symptoms and status of residents changed quickly; therefore, the collaboration between palliative care, the providers, and ALF staff was essential.

Because of the quick decline of residents, and rapid conversations with family, many were identified for hospice care, but not all were officially placed on hospice. Those not formally admitted were given "hospice-like" care and support. Along with holistic management of the patient, bereavement needs were also identified for the families at the ALF, especially in these circumstances that placed family members at risk for complicated grief. Bereavement support was also offered to staff who had developed significant relationships with residents and needed a method to manage loss and grief.

Lessons Learned

Lessons learned from dealing with an evolving crisis should be considered if and when future surges reintroduce the virus in communal settings. These lessons can also be applied to future pandemics, new viruses, or disaster preparedness situations. Most facilities have procedures to ensure that staff are not infecting residents, which can be adapted for essential visitations by family and caregivers. Facilities can stagger visits, limit areas, and require temperature checks, masks, and proof of COVID-19 testing. The risks and benefits have to be considered, which will require an increased demand for staff time. Still, visits from family may improve patients' functional status and reduce telephone calls and worried inquiries from family.

A study in the Netherlands found that restrictions on visitors and movement in the facilities have impacted residents' autonomy and right to make their own decisions. Despite video calls and creative methods of visitation (eg, window visits), residents still felt socially isolated. The Netherlands government piloted visitation 8 weeks after the initial ban, which included allowing 1 visitor per resident with set national guidelines. These guidelines, similar to Germany, France, and Belgium, included the use of hand sanitizer, masks, temperature checks, staggered visits, and 5 ft of social distancing from staff and other residents. Results showed that no new COVID-19 cases were reported from the 26 participating nursing facilities 3 weeks after visits were allowed. More than 730 cases were reported at the national level during the same period.²³



NURSING IMPLICATIONS

During a public health crisis, the existing structures for the provision of care are not always optimal for containing the epidemic. Palliative care nurses are skilled at providing patient-centered, holistic care across the continuum of care and therefore are the ideal professionals to supplement care in a communal setting where additional staff are needed. These skills are also transferable to a population subject to a common threat in the planning and preparation in a public health approach. The use of nursing skills in triage and assessment, principles in public health, and the 8 domains of palliative care can provide a comprehensive framework for structuring emergency operations during surges in the pandemic.

Nurses are responsible for coordinating individual plans of care in the context of the restrictions presented by the crisis, while maintaining precautions that will minimize risk to the greater population. Containing the spread of infection and managing acute physical issues to avoid hospitalization may appear to be the primary objective, but an awareness of the risks that meeting this objective presents to social, emotional, psychological, and spiritual domains is no less critical to the quality of life of individuals within the population.

A fundamental of nursing practice is that immobility inherently undermines health and well-being, and yet in pandemic conditions, mobility and social interaction are deliberately restricted. Palliative care nurses are positioned to take a broad view of how changes in operations can affect the individuals and their community and to work with the IDT to work on solutions to circumvent these problems on an individual and on a structural basis, even if these measures will only last for the duration of the restrictions.

LIMITATIONS

This case study is a singular example of an outbreak at a facility and may not be generalizable to all settings. These residents are a part of a community health system and had access to resources and personnel. Lower-income communities or those that are isolated may not be capable of the same staffing, supplies, or support. In addition, the population at this facility was homogenous. Residents were mostly White and at a high socioeconomic level to afford to reside in the facility. The same results may not be transferable to residents living at a facility with different demographic and socioeconomic backgrounds. Finally, this facility was an ALF with different regulations and processes as a nursing home or group home. Results from this case study may not be similar to those in another facility with greater or less regulatory restrictions.

CONCLUSION

As best practices for managing care in a communal setting continue to evolve, palliative interventions can and should play an integral role. Individual autonomy was challenged on multiple fronts with government restrictions, such as the moratorium on outside visitors and nonessential service providers. Operational changes within the health care organization also imposed limitations on individual choice. Communal activities were suspended, creating further isolation and impeding the social connectedness of residents. All of these factors were necessary at the onset of the pandemic, but the effects on residents' well-being could have lifelong implications. The ethical challenges surrounding containment of the virus need to be balanced with the deleterious effects of social isolation among the elderly in eldercare facilities. The 8 domains of palliative care provide an effective framework for mitigating the unintended consequences of infection control and balancing individual rights against the health of a population.

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