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No Visitors Allowed! The Impact of COVID-19 Restrictions on the Psychosocial Well-Being of Nursing Home Residents

RESEARCH

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ABSTRACT

Context: The COVID-19 pandemic changed life for everyone, but especially for nursing home residents. In March 2020, the Centers for Medicare and Medicaid Services in the United States enacted nursing home restrictions regarding visitation from outside family/friends and changes to facility activity programmes.

Objective: This study explored the nursing home policies and practices that preserved relationships among nursing home residents with spouses/partners. Nursing home social workers shared the effects of COVID-19 restrictions on residents' relationships with spouses/partners and how they sought to maintain these essential social connections to minimise the detrimental effect on the psychosocial well-being of residents.

Methods: The study utilised both an online survey and 10 telephone interviews with nursing home social workers in four southern states.

Findings: Twenty-eight percent of participants reported that no visitors were allowed, while 25% allowed couples to visit with one another as usual. The most noted practices to maintain social connections were phone calls, video calls, and 'window' visits between residents and family/friends; however, as one respondent noted, 'It's just not the same. It's affected them greatly.' Interviews revealed further details about the detrimental effects of the COVID-19 restrictions on nursing home residents' overall mental health and attachment relationships with spouses/partners.

Limitations: Study limitations exist in the focus on practices in four south-eastern states, with no inclusion of northern US states. An additional limitation of sampling is discussed.

Implications: These results highlight the importance of maintaining social connections between residents and spouses/partners. Policies and practices that enhance relationships and connections under all circumstances should be formalised and all health care team members trained to ensure implementation.

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INTRODUCTION

In March 2020, the entire world was ravaged in the wake of the spread of the coronavirus, a potentially deadly virus that can affect the respiratory system of the individual who contracts it (World Health Organization, 2020). Preventive measures to mitigate the spread such as social distancing, the mandating of face masks in public settings, and gathering restrictions are some of the most well-known practices. Businesses with some of the most notable restrictions were those that provide health care and long-term care services, including hospitals and nursing homes. In these settings, restrictions were apparent, as visitation was either limited or banned altogether. COVID-19 symptom screenings were conducted before entering most health care facilities. Restrictive practices in nursing home settings were very similar to those observed in hospitals, including limitations on visitation from family and representatives from some outside services, such as hospice. In many facilities, visitation was only allowed in cases of significant decline and/or near the end of life.

Although the purpose of limiting visitations was to slow or stop the spread of COVID-19 amongst nursing home residents, the impact of this restriction on the mental and emotional well-being of residents was not explicitly considered. This was specifically a concern for nursing home residents who have a spouse/partner with whom they may have a strong attachment relationship. The objective of this study was to explore the impact of COVID-19 restrictive practices in nursing homes on the mental and emotional well-being of nursing residents with a spouse/partner. In addition, this study also served to highlight the techniques used by nursing home staff to maintain social connections between residents and their spouses/partners.

COVID-19 AND NURSING HOME RESIDENTS

Although all older adults, especially those with chronic diagnoses, are at high risk for experiencing COVID-19-related complications, many older adults residing in the nursing home setting face additional challenges in efforts to remain safe during the coronavirus pandemic. In the United States, approximately 71% of nursing home residents have a diagnosis of hypertension, 32% have diabetes, 26% have arthritis, and 12% have osteoporosis. Other debilitating illnesses, such as coronary artery disease, congestive heart failure, and stroke, are experienced by 38% of nursing home residents (Harris-Kojetin et al., 2019). In addition, the communal nature of nursing homes makes it difficult to maintain a safe distance between each resident, further increasing the risks of spreading the communicable disease. Communal living in the nursing home setting refers both to the sharing of rooms (two residents per room) and the sharing of activity and dining areas.

In March 2020, considering these risks and the spread of COVID-19, the Centers for Medicare and Medicaid Services (CMS) and many states enacted new visitation, screening, and activity procedures. CMS put into place the following restrictions and guidelines:

- Restricting all visitors, immediately, with exceptions for compassionate care, such as end-of-life situations.
- Restricting entry to all volunteers and nonessential health care personnel and other personnel (i.e., barbers);
- Canceling all group activities and communal dining within facilities; and
- Implementing active screening of residents and health care personnel for fever and respiratory symptoms (Centers for Medicare and Medicaid Services, 2020).

The implementation of these restrictions not only impacted the day-to-day operations within nursing home facilities for staff but also resident-to-resident communication, resident-to-staff communication, and resident communication with loved ones outside the home. This communication breakdown has been reported in nursing homes and COVID-19 research. For example, O'Caoimh et al. (2020) explored the impact of COVID-19 nursing home restrictions on the psychosocial well-being of residents with cognitive impairment in Ireland. Study findings highlight a decrease in communication between residents and nursing home staff as a result of restrictive practices (O'Caoimh et al., 2020). On this same note, another article highlighted an increase in depression and anxiety, worsening dementia, and failure to thrive because of social isolation (Abbasi, 2020).

NURSING HOME RESIDENTS WITH SPOUSES OR PARTNERS

Although all nursing home residents were affected by the implementation of these new guidelines, nursing home residents with spouses/partners faced additional challenges in the form of a threat to these essential attachment relationships. Gerontological research about spousal relationships in the nursing home has primarily focused on staff attitudes about intimacy and sexuality amongst residents, with a significant amount of literature focusing on ethical aspects of intimacy for residents with dementia (Helen, 1995; Simpson et al., 2018; Walker & Ephross, 2008; Roelofs et al., 2015). Additionally, studies in this area also highlight the importance of intimacy for nursing home residents. For example, a quantitative study examining the psychosexual needs of nursing home residents found that participants expressed a need for physical closeness (45%) and a need for tenderness (75%) (Mroczek et al., 2013). In a similar study, Bullard-Poe and Powell (1994) interviewed 45 male nursing

home residents and found that intimacy amongst this group was seen to contribute to quality of life.

Despite the significant role that intimacy plays in overall quality of life and psychosocial well-being amongst nursing home residents, no literature was found that described the types of services or facility practices or services that are available for the preservation of relationships between nursing home residents and their spouses/partners. Although nursing home regulations emphasise the importance of addressing each resident's psychosocial needs, little attention is given to policies and procedures to assist nursing home staff in supporting relationships amongst residents and their spouses/partners during a nursing home stay. This study explored service/programme availability for residents who have a spouse/partner. The social work role in service delivery and development of specific policies and guidelines utilised for implementation of such services was also explored.

In 2021, approximately 20% of US nursing home residents reported that they were married when administered the Minimum Data Set (MDS) assessment. MDS assessment reports also show that approximately 25% reported never being married, 35% were widowed, and 18% were separated or divorced (Centers for Medicare and Medicaid Services, 2021). To combat this decrease in socialisation, many facilities encouraged their residents to maintain these social connections through the use of technology services such as FaceTime, Zoom, and/or Skype while also facilitating window visits. As a result, many facilities were also forced to increase staff availability to implement these COVID-friendly techniques (Ickert et al., 2020).

ATTACHMENT THEORY AND NURSING HOME RESIDENTS

The use of alternative methods to maintain attachments is essential, specifically when considering the role that an attachment relationship plays in an individual's life. This can be further explored through attachment theory. In attachment theory, Bowlby (1987) describes the interaction and connection between a mother and her child and the importance this bond has on the child's development. However, Bowlby suggests that attachment theory can be applied from the 'cradle to the grave' (Bowlby, 1987). Hazan and Shaver (1994) further explored this concept and identified similarities between the 'infant-caregiver' and 'romantic partner' relationships. In each of these attachment situations, both (infant and romantic partner) feel safe when the other (caregiver and romantic partner) is nearby and when they engage in close, intimate bodily contact, and they feel insecure when the other is inaccessible (Fraley, 2010). Close relationships play a vital role in human physical, emotional, and mental development at all stages of life. The disruption or loss of a relationship can affect older adults in many aspects of life, including mental, social, behavioural, and biological (Das, 2013; Hunt, 2015).

METHODOLOGY

As a part of a larger study, Authors (2021) explored the preservation of spousal and partner relationships amongst nursing home residents. This study used mixed method research to explore the effects of COVID-19 restrictions on the psychosocial well-being of nursing home residents. Although the focus of the larger study was facility policies and services, routine practices and demographics, and participant personal and professional background demographic, an additional focus included COVID-19 services and facility restrictions. Through the Qualtrics online survey platform, participants completed a survey with items related to relationship-preserving nursing home policies and COVID-19 pandemic practices. The survey also contained an invitation for respondents to participate in a semistructured interview (see below for sampling and recruitment details). The following research questions were the focus of this study:

- How have COVID-19 restriction practices impacted the psychosocial well-being of nursing home residents who have a spouse or partner?
- What tools and techniques have nursing home staff used to maintain social connections between nursing home residents and their spouse or partner?

SAMPLE AND PROCEDURES

In the nursing home setting, through an interdisciplinary team approach, social workers collaborated with the other facility disciplines (nursing, rehabilitation, nutrition, etc.) to develop and implement an individualised plan of care for each resident. The social workers' primary contribution to the interdisciplinary team is ensuring that each resident's psychosocial needs are addressed. To achieve this goal, social workers are responsible for various activities, including completing a mental health assessment, conducting psychosocial interventions, counselling residents and their families, making referrals to other service providers, evaluating the resident's progress and functioning, preparing a discharge plan, and assisting the resident with palliative care (Rehnquist, 2003). Additional duties may include implementing behaviour management programmes, participating in group work, and attending quarterly care plan meetings (Bern-Klug & Kramer, 2013).

In consideration of their various roles and responsibilities and overall focus on residents' psychosocial well-being, social workers were the best

informants for this study. The sampling frame included licenced social workers, including social service directors, employed at CMS-certified nursing home facilities located in the states of Alabama, Georgia, Mississippi, and Tennessee. As of January 2020, there were 234 certified nursing homes in the state of Alabama, comprising just under 1.5% of all nursing homes in the United States (Alabama Department of Public Health, 2020). The state of Georgia contained the greatest number of certified nursing homes, with a total of 352 facilities (2.25%), followed by Tennessee with 319 (2%) and Mississippi with 204 (1.2%) (Georgia Department of Community Health, 2020; Mississippi Department of Health, 2019; Tennessee Care Planning Council, 2012).

A power analysis was conducted to identify an appropriate sample size as a 'best practice' guideline for a quantitative survey. The power analysis determined that a minimum sample size of 45 participants will provide a confidence level of 95%, representing the likelihood of not committing a type I error. Additionally, in consideration of the low response rate of online surveys (20%), a sample size of 225 survey respondents was targeted (Blair et al., 2014).

At the end of the survey, an additional item contained an invitation for respondents to participate in a semistructured interview. Those interested provided their name and contact information. A total of 34 survey respondents provided their names and contact information for potential participation in semistructured interviews. A total of 10 participants were selected to participate in the semistructured interview. To achieve a diverse sample of interview participants, respondents were selected based on various factors, such as location facility, gender, and year of practice experience in the nursing home setting. The use of semistructured interviews allowed for further exploration of common practices in the nursing home setting for preserving spousal and partner relationships and barriers experienced when carrying out these practices.

RECRUITMENT STRATEGY

According to CMS guidelines, nursing home facilities with more than 120 beds are required to employ a licenced social worker (Social Work Policy Institute, 2010); therefore these facilities (e.g., 106 of 234 in Alabama) were automatically included in the sample manner. To increase the sample size, each facility in Alabama with fewer than 120 beds was contacted by phone to determine the presence of a licenced social worker, yielding an additional 28 respondents. In a further effort to increase the sample size, nursing home social workers in the states of Georgia, Mississippi, and Tennessee were also included. In Georgia, 117 nursing home facilities had at least 120 beds, and in Mississippi, 58 facilities fell into this category. Additionally, in Tennessee, 138 nursing home facilities had more than 120 beds. In summary, a total of 447 potential respondents were identified.

Each identified facility was contacted by phone to obtain the name and email address of the facility's social worker. The collected names and addresses were kept in a password-protected Microsoft Excel document. A total of 95 names and email addresses of social workers were collected in Alabama. Additionally, 73 were collected from Georgia, 36 from Mississippi, and 60 from Tennessee. Therefore, the survey was distributed to a total of 264 nursing home social workers.

An initial email containing a cover letter, an explanation of the purpose of the study, and a link to the survey was distributed to respondents using the Qualtrics system. After providing consent to participate by clicking the consent button, respondents were then prompted to begin the survey. Data collection took place between July and September 2020. Three reminder emails in total were sent: one two weeks after the initial email and then one in each of the two subsequent weeks. Reminder emails were also distributed through the Qualtrics system to respondents who had not completed their survey at the time the reminder email was sent.

A total of 264 survey invitations were emailed to potential respondents, and 110 respondents completed it, for a response rate of 41%. However, 29 responses were removed due to survey completion rates of less than 30%. The remaining 81 responses were used in the analysis. In addition, a total of 34 respondents expressed interest in participating in a semistructured telephone interview. Ultimately, 10 respondents were chosen to participate in a telephone interview. To obtain a diverse sample, the 10 respondents were chosen based on the state of practice, number of beds in the facility, and gender. Potential interview participants were contacted by email to schedule a phone interview date and time and received a $10 Amazon gift card for their participation. Additionally, all survey respondents and interview participants received a summary of the major findings of the study.

MEASURES

The survey instrument was composed of four domains: 'Facility Policies and Services Provided to Preserve Resident Spousal and Partner Relationships', 'COVID-19 Pandemic Services and Facility Restrictions', 'Facility Routine Practices and Demographics', and 'Social Workers' Background Information (Professional and Personal)'. The first domain, 'Facility Policies and Services Provided to Preserve Resident Spousal and Partner Relationships', contained questions related to each facility's policies and programmes regarding residents who have a spouse or partner. This domain was composed of 25 questions.

Eleven items collected categorical data and included an 'other, please specify' option to allow respondents to add a specific response if theirs did not 'fit' into any of the listed categories. As an example, for the question 'What type of accommodations or services are included in your facility's written policy?', respondents were able to choose from these categories: 'Private space accommodations for resident and spouse to visit', 'Private meals or dinner accommodations', 'Couples activities', 'Couple outings', 'Other (please specify)', and 'No special accommodations'. Seven questions in the first domain were all open-ended. Open-ended questions in this section allowed respondents to provide specific information about their facility's policies and programmes. For example, a question in this section asked, 'Within your facility's organised activities programme, what type of activities might serve to preserve spousal or partner relationships between residents and their spouse or partner?' Other open-ended questions in this section required a numerical response. For example, 'Currently, how many residents in your facility share a room with their spouse or partner?'

Because this section asked respondents to provide information related to their duties and tasks, seven questions in this section contained responses that were measured on an interval level. Ordinal responses provided respondents with an opportunity to score the frequency of their participation in certain facility functions. For example, one question read, 'During your workday, how often do you communicate with other team members about residents' psychosocial needs?' Respondents identified, on a scale of 0 to 10, how often they participate in the identified tasks. In the interval response options, 0 suggested the lowest frequency, while 10 suggested the highest level of participation.

'COVID-19 Pandemic and Facility Restrictions' was the second domain in the survey. This domain was composed of a total of 11 questions. In March 2020, in response to the spread of COVID-19, the CMS and states enacted new visiting, screening, and activity procedures. CMS put into place the following restrictions and guidelines:

- Restricting all visitors, effective immediately, with exceptions for compassionate care, such as end-of-life situations;
- Restricting all volunteers and nonessential health care personnel and other personnel (i.e., barbers);
- Canceling all group activities and communal dining; and
- Implementing active screening of residents and health care personnel for fever and respiratory symptoms (Centers for Medicare and Medicaid Services, 2020).

Because these restrictions and guidelines directly influenced nursing home residents' ability to visit and interact with their loved ones, and to capture data about this historical event as it affected relationships, questions related to the COVID-19 restrictions were included in both the survey and the interview protocol. This domain was composed of a total of 11 questions. The COVID-19 section of the survey contained questions about each participant's facility policies and practices during the COVID-19 pandemic. Eight questions in this domain allowed respondents to select a response from various nominal options. For example, in answering the question 'Did/Has your facility made any exceptions regarding visitation for residents who have a spouse that lives in the community?', respondents were able to choose from nominal categories 'Yes', 'No', 'I don't know', and 'Other (please specify)'. Three questions in this domain were open-ended. One question asked, 'What kind of visitation was allowed for spouses or other family members for residents who were actively dying?' Respondents were asked to describe their facility's visitation procedures for this situation.

The third domain, 'Facility Routine Practices and Demographics', included descriptive questions about the respondent's facility. This domain contained a total of eight questions. Two questions in this domain were measured on a nominal level, with the remaining four requiring an open-ended response. One question asked, 'In which type of community is your facility located?' Respondents were able to choose from the following: 'Large metropolitan', 'Small metropolitan', 'Rural or small town', 'Suburban area', and 'Other (please specify)'. Open-ended questions in this section required numerical responses related to caseload, social work staffing, and facility capacity. For example, respondents were asked to identify their average weekly caseload. Six questions in this domain required an open-ended response.

The fourth and last domain, 'Social Workers' Background Information (Professional and Personal)', focused on obtaining information about the respondent's professional and personal background. This section contained a total of nine questions, five of which included nominal category responses, and the remaining four were open-ended. One of the nominal questions in this category asked respondents to identify their highest level of education. Respondents were able to select 'Bachelor's degree', 'Master's degree', 'Ph.D./DSW', or 'Other (please specify)'. Open-ended questions in this section asked respondents for numerical data. For example, one question asked, 'How many years have you been practicing social work in the nursing home setting?' Table 1 provides a listing of each survey item corresponding to each research question. At the end of the survey, respondents were given the option to participate in a telephone interview by inserting their contact information for future contact.

The interview guide for this study contained a total of nine questions. Each question was taken from at least one of the domains outlined in the study's

VARIABLES		SURVEY RESPONDENTS		INTERVIEW PARTICIPANTS	
		n	%	*n*	%
Gender	Female	70	87.5	7	70
	Male	10	12.5	3	30
Race	Caucasian, non-Hispanic	56	71.8	6	60
	African American, non- Hispanic	19	24.3	3	30
	African American, Hispanic	2	2.6	–	–
	Native American	1	1.3	1	10
Age	24–34	21	26.6	6	60
	35–45	28	35.4	4	40
	46–56	22	27.8	–	–
	57–71	8	10.2	–	–
Years in Current Position	Less than 1 year	12	15	1	10
	1–10 years	51	64	8	80
	11–20 years	12	15	1	10
	21–30 years	4	5	–	
	31–40 years	1	1	–	
State	Alabama	29	35.8	5	20
	Georgia	24	29.63	2	20
	Mississippi	7	8.64	1	10
	Tennessee	21	25.93	2	20
Highest Degree	Bachelor's Degree	44	55	3	30
	Master's Degree	32	43.75	7	70
	Ph.D./DSW	1	1.25	0	0
Social Work License Type	Clinical	5	7	2	20
	Graduate	13	18	2	20
	Bachelor	31	42	4	40
	No License	21	29	2	20
	Other	3	4		

Table 1 Respondent and Participant Demographics.

Note: Due to missing data the total *n* available for each item varies: gender *n* = 80; race *n* = 78; age, respondent years in position, n = 80; highest degree *n* = 80; social work licensure type *n* = 73.

survey. Interview participants were asked to provide information about their duties and responsibilities in their facility, current relationship-maintaining practices, ideal relationship-maintenance programme components, and COVID-19 restriction practices.

Following the development of the survey, it was pretested with four nursing home social workers, from whom feedback was used to finalise the instrument. The pretest data were not included in the data analysed in determining results; they were only used to refine the survey. The research protocol received approval from the institutional review board of the researchers' universities.

DATA ANALYSIS AND SOFTWARE USE

The data analysed for this study was related to COVID-19 and restrictions in both the online survey and the follow-up interviews. Data analysis was guided by each research question and survey item. Questions that collected quantitative data were analysed with descriptive statistics, including percentages, means, and frequencies. The semistructured telephone interviews, after transcription, were analysed using N-Vivo. Provisional coding occurred in the first cycle of analysis. This type of coding utilises researcher-generated predetermined codes to apply

to data (Miles, Huberman & Saldana, 2020). Provisional codes reflected each of the interview questions. In addition, subcoding was used to further analyse and identify common themes within each provisional code. Two coders were used to analyse data.

Also, 8 of the10 interview participants provided feedback for the member-checking process. All of these participants thought that the identified themes were accurate and had no additional suggestions.

RESULTS

RESPONDENTS' DEMOGRAPHICS

Most survey respondents were female, consistent with the field. Additionally, the highest percentage of respondents identified as Caucasian (non-Hispanic), and their ages varied between 35 and 71. Similarly, the interview participants mirrored the survey respondents' demographics. The largest percentage of survey respondents were from Alabama, followed by respondents residing in Georgia, Tennessee, and Mississippi. In addition, for interview participants, the years of practice in their current position varied greatly, from 4 months to 20 years. Similar variation is observed in years of practice for survey respondents, ranging from 2 months to 36 years (Table 1).

Respondents' highest educational attainment and licensure type varied as well, as seen in Table 1. The largest group of respondents reported a bachelor's degree as their highest educational level, while master's degree recipients were less represented. Respondents with a Ph.D. or DSW made up the smallest percentage of respondents. In addition, 70% of interview participants reported a master's degree as their highest level of education.

COVID-19 RESTRICTIONS

Regarding facility restrictions during the coronavirus pandemic, changes to residents' visitation rules were most frequently reported. Suspension of residents' activity programmes was also frequently mentioned. A few respondents shared additional restrictions, such as changes to facility activity programmes (rather than suspension), prohibiting visitation from certain outside agencies but not all, and changes to residents' meal settings. Exceptions to visitor restrictions were further explored, with the most commonly reported reason for exception involving situations in which the resident was actively dying (Table 2).

Respondents also provided information about their facility's efforts to maintain social 'connections' between residents and their families and friends (see Table 3). Respondents most frequently reported that their facility organised phone calls, video chats, and visits through a glass door or window. In addition, over one-half of the respondents reported that their facility did not make any special efforts to facilitate in-person visits. Those that made special efforts for their residents to participate in in-person visits identified activities such as window visits, allowing visitation if a resident was actively dying, and 'drive-by' visits.

These mitigating practices were further explored through semistructured interviews, in which participants also shared their facility's practice techniques to preserve residents' relationships with their loved ones during the COVID-19 pandemic. The most frequently mentioned mitigating techniques were video calls and window or plexiglass visits. Participants whose facilities utilised video calls during the pandemic mentioned the use of Skype, Zoom, and FaceTime for these calls. One participant described how their facility organised window visits:

> Window visits where there is a sitting area for the family in front of the window and there is a sitting area for the resident and there is a phone that connects them. We can put it on speaker, or we can hold the phone, so you don't have to use your cell phone and the landline connection is a little better that way. So, they can see each other through the window.

VARIABLES		*n*	%
Facility Restrictions	All residents' visitors were not allowed in the building	79	41
	No outside agency personnel were allowed in the facility	34	18
	Resident activity program suspended	48	25
	No restrictions were put into place	14	7
	Other	18	9
Exceptions for Residents	Yes	26	33
	No	54	67

Table 2 COVID-19 Facility Restrictions.

Note: For facility restrictions respondents selected all that applied; exceptions for resident *n* = 80.

VARIABLES		*n*	%
Maintaining Social Connections	Organize phone calls between residents and their friends and family members	77	28
	Organize and facilitate video chats between residents and their friends and family	76	28
	Ensured presence of residents in care plan meetings with family members	31	11
	Allowed residents to visit with friends and family member through a glass door or window	77	28
	Other	13	5
Efforts to Facilitate in-Person Visitation	Yes	29	36
	No	51	63
	I Don't Know	1	1

Table 3 Maintaining Social Connections.

Note: For maintaining social connections respondent selected all that applied.

RESTRICTIONS	*n*	%
No restrictions-spouses and partners were allowed to visit with one another as usual.	20	25
Spouses and partners were allowed to visit with one another for only a specified time.	3	4
Close monitoring of residents' spousal and partner visits by facility staff	9	11
Spouses or partners were not allowed to visit with one another	23	28
Other, please specify	26	32

Table 4 Spouse/Partner Restrictions.

Another participant shared a similar experience:

> For a while, we were able to do window visits and that sort of thing. Even though that wasn't the same as physical contact, that was better than nothing. I think when we had to stop those [window visits] I think that probably hurt us the most. We try FaceTime but with our residents with dementia and those type of diseases they don't understand FaceTime at all, so that's been difficult.

Another participant shared that 'sometimes there are multiple family members that participate. But the activities department they will take a tablet in to the resident so that they can have some private time with their family.' Additional mitigating techniques included in-room activities and encouraging residents to speak with their loved ones via phone as much as possible. Due to COVID-19 restrictions, nursing homes were no longer able to have group activities or communal dining. As a result, nursing homes were forced to make changes to the way activities were carried out in the facility. For example, one participant reflected on their facility's efforts in this regard, stating, 'We amped up some of our activities but it would have to be room to room. We would do homemade ice cream and make non-alcoholic margaritas. Just little things to pass from room to room.'

The survey also included questions about facility practices specifically for residents who have a spouse or partner. Many respondents shared that spouses and partners were not allowed to visit with one another face-to-face, while a slightly smaller percentage of respondents did not enforce visitation restrictions, thus allowing spouses and partners to visit with one another as normal. Many participants shared that their facility did not currently have any couples (Table 4).

Many respondents identified other facility practices, including socially distanced visits and changes in room arrangements (spouses share a room), and other facilities allowed no visits at all. Respondents believed that some COVID-19-related restrictions might continue long term. Staff screening upon entering the facility was reported most frequently, along with quarantine requirements for new admissions and staff requirements to wear personal protective equipment (PPE). Other responses for this item included staff education, eliminating semiprivate rooms, and PPE for isolated residents (see Table 5).

Interview respondents also provided insight into their facility's restriction practices and the effect that these practices have had on relationships between residents

and their spouses or partners. In describing the impact of the COVID-19 restrictions on spousal and partner relationships, all 10 interview participants stated that the restrictions have had a negative effect not only on residents' relationships with their spouses or partners but also their mental health. Participants shared their observations of mood changes, physical decline, and difficulty coping with the death of a spouse during the pandemic. One participant also reported an increase in prescriptions of antidepressants since the COVID-19 restrictions were put into place. Another participant shared a vivid description of the impact of these restrictions on a particular resident in their facility and their community-dwelling spouse:

> It's affected them greatly. Even with the spouses that are in the community that has a wife or a husband here that can't see them as much and can't talk to them as often, they have to rely on staff. … They are having to see them through a window right now. It's just not the same. It's affected them greatly. I think of one little elderly guy who comes every day to see his wife through the window. He's constantly asking 'when can I come in'. It's having a huge impact on their relationship. And just their mental health. It's almost breaking their bond.

Another participant shared, 'From a social worker perspective, I would say all of them [restrictions] were detrimental. From a medicine perspective I one hundred percent get why they were enacted.' Yet another participant stated,

> It's [restrictions] been a big detriment to all of our residents. Like I said we have the one husband who is used to coming up here and spending every afternoon with his wife and they haven't seen each other since March. So, for them, it's been a huge detriment to them from not being able to see one another.

Many participants reported observing declines in residents' overall well-being due to lack of contact, specifically among residents with dementia, or were otherwise unable to report mood changes.

Respondents were also asked about their role in COVID-19 policies/restrictions and changes in their daily work. Most respondents reported they were not involved in the development of their facility's protocols/policies to address the COVID-19 pandemic. Regarding changes to respondents' daily work, an increased focus on residents' connections with their families was reported most frequently. Providing emotional support for co-workers and assisting with staff screening for COVID symptoms were also often reported. Other responses included providing frequent updates for residents and their families, facilitating communication between residents and their family members, providing emotional support to residents, and creating virtual activity opportunities.

DISCUSSION

The motivation to conduct the current study was influenced by John Bowlby's attachment theory. The theory suggests that 'children come into the world with an innate drive to form attachments with their caregivers' (Bretherton, 1992), but, as noted above, the key concepts of attachment theory may apply throughout adulthood as well (Bowlby, 1987). Others have explored connections between child-adult intimate attachments and adult-adult ones (e.g., Hazan & Shaver, 1994; Fraley, 2010). Spouses often seek 'closeness to their partners, experience distress if they become unavailable, derive a sense of security from their relationships, and turn to partners for comfort in times of stress' (Feeney & Hohaus, 2001).

RESTRICTIONS/POLICIES	*n*	%
Staff requirement to wear PPE such as masks or gowns	55	15
Quarantine requirements for new admissions	63	18
Visitation Restrictions	44	12
More Frequent Vital Checks for Residents	49	14
Social Distancing During Resident Activities	42	12
Non-communal Dining	28	8
Staff Screening Upon Entering Facility	70	20
Other	4	1

Table 5 Long-Lasting Restrictions/Policies.

Note: Respondents were asked to select all that applied.

Close relationships play a vital role in human physical, emotional, and mental development at all stages of life. The establishment and maintenance of close relationships is thought to be essential for the personal well-being of most people (Freedman, 1978). For older adults, these relationships are especially important. The disruption or loss of a relationship can affect older adults in many aspects of life, including mental, social, behavioural, and biological (Das, 2013).

The results of this study highlight the effect of the COVID-19 pandemic on nursing home residents (up until the point of the data collection). As previously stated, since March 2020, nursing homes have been forced to change their day-to-day operation in an attempt to ensure the safety of their residents, many of whom fall into the groups most at risk for severe COVID-19 complications.

Due to these operational changes, restrictive COVID-19 protocols have also affected both the psychological and physiological well-being of nursing home residents, specifically those who have a spouse or partner. Participants identified several indicators of damaging effects, including changes in resident mood, exacerbation of cognitive symptoms, and an overall lack of social interactions since the COVID-19 restrictions were implemented. Several participants shared that they understood the purpose of the restrictions as protecting each resident's physiological health, but lack of attention given to the impact of restrictions on the psychosocial well-being of residents was evident. This is further emphasised in participants' observance of an increase in the prescribing of psychotropic medication, worsening dementia symptoms, and the overall acknowledgement of the detriment of restrictions on spousal and partner relationships. They shared some of the words of spouses in the community about how they experienced the restrictions.

These findings further underscore the concept of attachment theory and the impact that the loss of an attachment can have on an individual 'from the cradle to the grave' (Bowlby, 1987). In consideration of Bowlby's attachment theory and the continued spread and constant evolution of COVID-19, it is essential for nursing homes to continue to pinpoint effective techniques to maintain social connections between nursing home residents and their spouses or partners.

One of the most frequently reported methods used to maintain social connections was through the use of technologically based platforms to maintain social connections between residents and their spouses or partners. Software such as video chat and conferencing and other smartphone features were mentioned. This same increase in technology use during the COVID-19 pandemic can also be observed amongst the general population, as more people turned to video conferencing, as opposed to face-to-face interaction, to slow the spread of the virus. Although the importance of technology has been apparent throughout the coronavirus pandemic, the use of technology to perform day-to-day tasks has become commonplace in our society from matters as trivial as social media use to more important work-related tasks (McClain et al., 2021). One major video conferencing company, Zoom, saw an increase in accounts at a rate of 353% in March 2020 (Haider & Rasay, 2020).

Although technology has made communication and access to information more readily available to most, not everyone or all ages have acclimated to these advancements. In one study exploring the perspectives of older adults in using technology to age in place, several barriers were all cited as factors that contribute to difficulties in technology use among older adults, including technology literacy, lack of familiarity with terminology, and physical challenges (Wang et al., 2019). Likewise, in another study exploring older adults' attitudes about technology, although participants expressed an overall positive attitude toward technology use, negative attitudes were reported in areas such as user-friendliness of technology platforms (too many features) and reliability of technology to function properly when needed (Mitzner et al., 2010).

However, research in the area of technology use among older adults coupled with qualitative data collected in the present study on this topic suggests a disconnect between the need for technology services, especially during the COVID-19 pandemic, and the ability of older adults to navigate these technology services. Given that many nursing home residents have complex functional disabilities, including cognitive, assistance is required for optimal use. Although many nursing homes have designated staff time to assist nursing home residents in technology use, staff availability was limited, given other COVID-related responsibilities in addition to usual non-COVID-related duties. Many nursing homes faced staffing shortages daily due to staff COVID-19 infection.

It is essential for nursing home administrators to investigate and identify technology services that are user-friendly and easily navigated by older adults. By incorporating and supporting user-friendly technology in efforts to maintain social connections, nursing home administrators can make great strides towards preserving spousal and partner relationships amongst nursing home residents who have a spouse or partner both during and following the height of the COVID-19 pandemic.

IMPLICATIONS FOR NURSING HOME STAFF AND ADMINISTRATION

In addition to training about technological strategies to maintain social connections, nursing home staff

should also be provided with training to acquire a basic understanding of the mood changes that residents may be experiencing due to COVID-19-related restrictions. In this study, one participant spoke about observing mood changes in residents who were unable to verbally express these changes. It is essential for all providers of care in this setting to be able to recognise significant mood changes and how this may affect the residents' overall mental health and well-being. Social workers are trained at the practice level and are equipped with the skills to recognise behavioural changes in nursing home residents and could provide this needed training to staff. This is also essential in consideration of the CMS guidelines regarding the reviewing and updating of care plans which need to change depending on residents' physical and mental health status. Nursing home administration must facilitate this type of training for staff who work directly with nursing home residents and also initiate the creation of protocols of what happens when a staff member notices a change, for example, immediate referral to the social worker for further assessment. Subsequently, earlier intervention can take place, and better outcomes can be realised.

Training assistance by the facility social worker should be augmented by members of the outside professional community who specialise in this area, including a psychiatrist or similar therapist who primarily works with older adults. Training is especially important in consideration of the overall well-being of nursing home residents who have a spouse or a partner. Training topics may include, but are limited to, the following:

- Review of common dementia and mental illness diagnoses amongst the older adult population and nursing home residents.
- Review of possible signs and symptoms of cognitive decline amongst nursing home residents.
- Emphasis on the impact of close relationships on the psychosocial well-being of nursing home residents.
- Review of proper steps to take following the observing of mood or behavioural changes, per facility-specific policies.

The study results also have implications for social work practice on an advocacy level. Although the COVID-19 pandemic has illustrated the potential and need for technology, it is essential to consider the benefits and limits of technology in the nursing home setting following the pandemic. This is especially relevant in considering the strong attachments that many nursing home residents have with their community-dwelling spouse or partner. Social workers in this setting can advocate on behalf of residents for user-friendly technology devices and support to facilitate smooth and frequent communication between residents and their spouses or partners, as well as other family members and friends. While many nursing homes provide landline telephones in residents' rooms, as well as on each unit, videoconferencing capabilities are not available on these devices. Therefore, residents may not have access to this visual component of communication.

STUDY STRENGTHS AND LIMITATIONS

This study had both strengths and limitations. One of the strengths of the study is that it addresses a gap in literature. Several studies have focused on the general impact of COVID-19 on nursing home residents. One study conducted in Ireland did focus on the impact of COVID-19 on the psychosocial well-being of nursing home residents, specifically those with cognitive impairment (O'Caoimh et al., 2020). In another study, Lood, Haak, and Dahlin-Ivanoff. (2021) explored the impact of the COVID-19 pandemic on the everyday lives of older adults living in nursing homes in Sweden, with findings emphasising the role of restrictive practices in diminishing the freedom of nursing home residents (Lood, Haak & Dahlin-Ivanoff, 2021). Although studies with this focus are an important contribution of literature in the area of nursing home residents and COVID-19, they do not address the impact of COVID-19 restrictive practices on spousal and partner relationships amongst nursing home residents and developments in homes to ameliorate the impact of these restrictions.

A primary limitation is that the survey respondents were sampled from four south-eastern states. As a result, the results of the survey are not nationally representative. However, it may be representative of COVID-19 practices and restrictions' effect on residents in nursing homes in the four represented states.

Another limitation is that since facilities in Georgia, Mississippi, and Tennessee with fewer than 120 beds were not included in the final sample, the proposed study was not able to capture service delivery to the population of interest in the smaller facilities in these three states. Also, the study utilised a self-administered survey, and both the researcher and the respondents were social workers. Therefore, due to social desirability, respondents may unconsciously provide responses that will present themselves well to the researcher or show their facility in a good 'light', and with self-report, there is a possibility for inaccurate or untruthful responses in general (Rubbin & Babbie, 2017). However, assurance of confidentiality and anonymity and the respondents' interest in the topic may mitigate this effect. The study sample only included social workers, and so the views and opinions of other nursing home staff are not represented.

There are many opportunities for future research in the area of COVID-19 and the psychosocial well-being of nursing home residents who have a spouse or partner. These efforts should be ongoing as the pandemic turns to the endemic stage in the community. A better qualitative understanding of the lived experiences of

nursing home residents with a spouse or partner during the implementation of COVID-19 restrictions is essential. Future research efforts in this area should also include all members of nursing home interdisciplinary teams who spend a considerable amount of time providing care to nursing home residents. Although the present study collected some of this data, study participants only included nursing home social workers.

CONCLUSION

In this study, the actions taken by nursing home staff to attempt to mitigate the detrimental effects of COVID-19 restrictions on the well-being of residents were seen as essential. An attachment theory lens helps to understand the importance of intimate relations across the life course and, hence, of their central value in the well-being of residents. The development of protocols 'at the moment' served the immediately evident need of the residents to maintain social connections and attachments to spouses and other important people in their lives. These protocols need to be evaluated for effectiveness and formalised into nursing home policies that can respond to future changes and challenges that threaten the psychosocial well-being of residents.

COMPETING INTERESTS

The authors have no competing interests to declare.

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