

## CASE STUDY

# The COVID-19 pandemic and resident-family and caregivers' relationships in nursing home: A case study

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## ABSTRACT

The COVID-19 pandemic bewildered the French population by its impact and particularly affected nursing homes. Older people living in nursing homes were at very high risk of being affected by COVID-19. This case study highlights its impact on resident-family dyad and caregivers' relationships. The suffering and anger manifested by all, the difficulty in managing the stress of the caregivers, the cognitive and physical deterioration of the residents and their social isolation show us that this unexpected pandemic has not only had psychological consequences on all those involved, but also calls into question the foundations of support for the older people. This pandemic is an opportunity to step back from what has happened and to ask ourselves how we can preserve residents' quality of life. Organization and measures need to be re-invented to limit and prevent the effects of this COVID-19 pandemic in the event of a resurgence of the virus.

**Key Words:** Nursing home, Residents, Family, Caregivers, COVID-19

## 1. INTRODUCTION

The COVID-19 pandemic bewildered the French population by its impact and particularly affected nursing homes. Statistics showed that more than 10,400 people died in nursing homes. Residents living in these nursing homes traumatically experienced the epidemic risk, containment, and de-containment and perhaps more than the French general population. This rupture in their continuity of existence created a before/after in their history. The case of Mrs. S. illustrates the effects of the COVID-19 pandemic on the relationships between resident-family-caregivers during three different times (i.e., the epidemic period, the containment, the de-containment).

## 2. CASE STUDY

### 2.1 Examination

Mrs. S, 86 years old, comes from the hospital where she spent two months following a stroke that left her with motor sequelae (loss of mobility in her left arm, difficulty in mobilizing physically and difficulty in leaning on her legs and standing). A few days after her stroke, Mrs. S fell down, and fractured her femoral neck. She underwent surgery and was referred to a physical rehabilitation service. During her stay in hospital, Mrs. S will indicate to a caregiver, "I don't want to live any more, what's the point? ". She completed Mini Mental State Examination (MMSE), Clock Test and Montgomery Abserg Depression Rating Scale (MADRS). These psychological tools indicated a cognitive impairment

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and a moderate depression. (23/30, 2/7 and 20/30, respectively). She eats less, asks to stay in bed as much as possible during the day and misses physical rehabilitation sessions. Returning to home seems not possible in these conditions. Mrs. S. lives alone at home, has been widowed for four years without any professional help, has no children and her trustworthy person is a young cousin close to her. The medical team in agreement with this trustworthy person proposes an entry in a nursing home located in Centre Val de Loire. Mrs. S is accepted in this establishment after the admissions committee has ascertained her consent during the pre-visit of the nursing staff at this hospital.

We are in March 2020, in epidemic period and the news from the nursing homes located in the East of France, the most affected by the COVID-19 are not reassuring. The nursing home where Mrs. S is, like the others will be closed to families as well as to the volunteers who regularly come to these establishments. Like everyone else, Mrs. S's cousin can call her by phone and is in connection with the caregivers every week. Mrs. S's cousin has also been unable to bring her things to personalize a room that he himself has not seen. Ms. S is now confined to her room.

## 2.2 Evaluation

The results of the questionnaires were transmitted and inserted in the personal file of Mrs. S. Then Mrs. S meet the psychologist, the day after her admission. She presents herself as a woman in withdrawal, "I'm here, what's the point?" She is not opposed to this meeting. However, she will end it after few minutes ("I'm tired, I want to sleep"). It is then difficult to conduct a psychological and cognitive assessment under these conditions. An appointment is rescheduled a few days later, but it will not last longer because Mrs. S will end it after few minutes (she falls asleep). During these few minutes, Mrs. S expresses not knowing where she was (hospital or nursing home). She has a loss of contact with the reality of external events.

## 2.3 Plan of care

At the same time as these unsuccessful appointments, support is provided by the occupational therapist to adapt the layout of the room and bathroom, and to assess Mrs S's physical capacities. Care is then fully taken care of by carers. Sometimes, Mrs. S wakes up at night, and it was suggested that the night carers provide her a snack. The meals are adapted, on a "food pleasure" mode. Little by little, the time of appointment with the psychologist increases, and Mrs. S spontaneously brings up the difficulty of not being able to meet her family. An appointment with the gerontopsychiatrist is proposed, and Mrs. S agrees to meet him only

to tell him that she refuses this follow-up. She indicates that "she is not crazy". A follow-up to take into account the suffering to be alone was set up. Phone calls have been set up in collaboration with his cousin. The care team has organized itself to maintain individual support times around games or accompanied outings. The occupational therapist set up individual physical mobilization activities, the psychologist organized individual interviews several times a week with each resident and telephone conversations with the family who felt the need. Leisure activities have been adapted and maintained despite the situation. Like all residents, Mrs. S benefited from it. All these elements are intended to limit vulnerability and social isolation. The depressive state of Mrs. S has gradually improved, and Mrs. S is gradually re-feeding herself. The caregivers highlighted that this resident was more involved in body care. However, shortly afterwards, Mrs. S falls again. Her psychological state deteriorates, her depressive state increases again, and the resident has no taste for anything.

When the national de-containment was announced, visits were set up under drastic conditions, including barrier gestures (i.e. washing hands, coughing into his/her elbow, being away each other), a temperature measurement, the wearing of a mask, a specific meeting place with no possibility of physical contacts and a maximum duration of 30 minutes. Mrs. S is very debilitated in a wheelchair. Her cousin, who expressed confidence in the team and had a positive view of the day-to-day support provided by the caregivers during the pandemic period, is now expressing his anger to the psychologist and physician. For him, these precautions are largely useless. In his opinion, the trustworthy person and the resident should have the opportunity to take a risk by making a visit without all these constraints, since this is their choice.

## 3. DISCUSSION

Some studies showed an exponential association between containment, its duration and risk of psychological distress,<sup>[1,2]</sup> and the international survey on coronavirus containment policies and their impact on the mental health of the general population (COCLICO survey) showed that containment did not spare older people in nursing homes.<sup>[2]</sup> The psychological effects of containment have already been described in the literature.<sup>[3]</sup> They range from an increase in boredom, social isolation, psycho-behavioral disorders (apathy, delirium...), to post-traumatic stress disorder, anxiety, depression, anger, and suicidal and addictive behaviors. Nevertheless, the effects of containment implemented during the COVID-19 pandemic is unprecedented. Mrs. S's case study illustrates the fact that containment (1) with the stress

induced by the pandemic and the associated consequences (e.g., fear of virus, strong reduction of social contacts) led to significant disruptions of biological rhythms and sleep patterns; and (2) was associated with increased anxiety, depression that could lead to dietary restriction.<sup>[1]</sup>

The nursing home has tried to overcome this by proposing a maintenance of a regular rhythm of meals and sleep, by promoting pleasant and stimulating activities or active calming strategies (meditation, relaxation), by promoting social contacts by phone. However other suggestions can be made.

### **3.1 Better supporting the relationship between the older person and his or her close relatives**

Some studies highlighted the importance of listening to and acknowledging the suffering of the residents during this period so that everyone can find their own way to respond to the reality of the virus as it has imposed itself on them.<sup>[4]</sup> This pandemic period is forcing the health care system to review the way it operates. The usual communication was particularly impacted by containment and distancing both for the resident-family dyad and resident-caregiver relationship.<sup>[5]</sup> This pandemic period showed that the lack of family support and physical contact were difficult for residents and their families to cope with, and this should lead health professionals to reflect on how to protect older people while at the same time ensuring their well-being, which is essential to their quality of life. Regarding Mrs. S, after the de-containment, she seems to regain confidence in her abilities every day. The health care team noted a physical and psychological recovery of this resident. Her cousin noticed her and was able to participate in the care in his own way by stimulating her with photos and supportive messages.

### **3.2 Strengthening ethical reflection**

In this nursing home, there is a space for collective ethical reflection which every month brings together the entire team of carers. With the COVID pandemic, this space did not work by lack of nursing time or impossibility to hold collective meetings and resumed only two months after the de-containment. This space works on principlism, a moral theory inspired by both utilitarianism and Kantism with four main principles (autonomy, beneficence, no-maleficence, and justice).<sup>[6]</sup> This pandemic period showed that this biomedical ethics was insufficient to think about the conflict between

residents' beneficence and autonomy. The risks of cognitive decline, vulnerability and physical decline are increased in residents during containment. Other forms of ethics can be used for helping to rethink situations : ethics of responsibility, ethics of care, ethics of discussion.<sup>[7]</sup> We believe that it is through discussion, concern for the most vulnerable persons and responsibility for maintaining barrier gestures and wearing masks that care in nursing homes should be organized.

### **3.3 Taking into account the carers**

This pandemic period should not obscure the risks for health professionals. Uncertainty remains a source of anxiety, and the organization can quickly become a source of stress. This context showed a weakening of the confidence of the resident-family-caregiver unit, and reinforced the caregivers' difficulties in dealing with difficult bereavements.<sup>[8]</sup> According to this author, the epidemic is questioning the ideal of care, its limits and makes these caregivers feel a sense of uselessness and a major anxiety in the face of death. It is important to better identify these vulnerabilities and difficulties in order to develop primary prevention strategies as well as training for these exposed caregivers.<sup>[9]</sup> Caring for the older people is essential, as is caring for caregivers. In this sense, a prevention project based on cardiac coherence is under way, in this nursing home, in order to reduce the psychological problems that may occur a few months after de-containment.<sup>[3,10]</sup>

## **4. CONCLUSIONS**

Through this case study, it is the health care system that needs to be rethought. The nursing home has shown that it was able to deal with this situation, but all actors were impacted. The epidemic is not over, and anticipation and prevention are necessary. Organization in nursing homes and measures need to be re-invented based on what has happened to limit and prevent the effects of this COVID-19 pandemic in the event of a resurgence of the virus.

### **ETHIC STATEMENT**

Written informed consents were obtained in accordance with the declaration of Helsinki.

### **CONFLICTS OF INTEREST DISCLOSURE**

The authors declare they have no conflicts of interest.

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