THE OTHER PANDEMIC: SOCIAL ISOLATION WITHIN LONG-TERM CARE FACILITIES DURING COVID-19

by

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Abstract

Social Isolation (SI) and loneliness are a worldwide concern among those living within long-term care facilities (LTCFs). This major paper sheds light on how COVID-19, which was declared a pandemic by the World Health Organization (WHO) in March of 2020, exacerbated SI and loneliness experienced by long-term care residents (LTCRs). Using a thematic review, recurrent themes and concepts were identified and analyzed under the frameworks of anti-oppressive and relational-cultural theory. Due to our ageing population and a need to ensure quality of life for those living longer, this topic is essential as SI is a health concern which results in multiple negative mental and physical health outcomes, including premature mortality.

The COVID-19 pandemic resulted in strict public health orders affecting LTCFs, LTCRs, and family members. These orders coincided with an increase in SI experienced by LTCRs who faced a lack of autonomy, personal agency and disconnection from family members who serve as social support and care providers for LTCRs. Furthermore, the media perpetuated ageist stereotypes of older adults as vulnerable and in need of protection, which influenced public health measures and access to medical care for LTCRs. These challenges were explored through a bioethical analysis.

Interventions to combat SI among LTCRs were identified at micro, mezzo and macro levels. This topic has largely been approached from a micro perspective, focusing on individual interventions despite the widespread prevalence of SI and loneliness within Canadian and worldwide. Additional research on this nuanced and emerging topic requires a social justice lens, looking at the ageist and structural factors which perpetuate SI within society.

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Dedication

I dedicate this to my three children, who have pushed me to have excellent time management skills.

Acronyms

AOP – anti-oppressive practice

BC – British Columbia

LTC – long-term care

LTCF – long-term care facility

LTCR – long-term care resident

RCT – relational cultural theory

SI – social isolation

WHO – World Health Organization

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Media coverage of the COVID-19 pandemic has brought greater public awareness to the issue of SI among LTCRs. Restrictive public health measures put in place by provincial health authorities has caused an upswing in SI experienced by LTCRs, which has been described as a secondary pandemic to COVID-19. SI should be acknowledged as a significant concern due to its impacts to mental and physical health, with a strong correlation to premature mortality (Bethell et al., 2021; Day et al., 2020). This major paper seeks to explore the topic of SI of LTCRs during COVID-19, through a social work lens. This is an important perspective to put forward in the research of SI in LTCFs, as this field is dominated by medical perspectives. A social work perspective will provide an understanding of SI from a holistic standpoint, acknowledging the structural aspects impacting SI within LTCFs. This perspective will assist practitioners working within LTCFs to develop multi-faceted interventions which combat SI and the underlying ageism which perpetuates this concern. The author relies on Relational Cultural Theory (RCT) and Anti-Oppressive Practice (AOP) to inform the research perspective. This major paper looks at the impacts of COVID-19 on SI of older adults living in LTCFs.

The author felt compelled to research this topic area as a result of the extensive media coverage and deaths of LTCRs due to infection from COVID-19. The author intends to further the commitment to improving the lives of those living in LTCFs through lasting structural changes, and thus approaches this topic from an advocacy lens.

This major paper is guided by one primary research question, followed by two secondary research questions.

- What are the effects of COVID-19 public health measures on SI of LTCRs?

- What role has ageism played in public health measures within LTCFs?
- What interventions to SI have been proposed within LTCFs?

Methodology

In order to develop a comprehensive understanding of this subject, thematic analysis was applied during the literature review to explore this topic, which involved identifying the recurrent themes and concepts relevant to SI and loneliness among LTCRs. Literature was retrieved through the Google Scholar search engine and through the EBSCOhost database. Key search terms included "*SI*," "*loneliness*," "*COVID-19*," "*coronavirus*," "*pandemic*," "*long-term care*" and "*assisted living*." These search terms were used in various combinations to capture relevant literature. All sources were retrieved from peer-reviewed research or scholarly articles. These key search terms yielded journals from predominantly medical fields, including nursing, geriatrics and palliative care. Few articles were found from social work and social policy disciplines. Given the novelty of the subject area and the finite research obtained, the author did not limit the search to a specific geographic area. Instead, peer-reviewed research was included from areas such as Canada, the United Kingdom, Australia and the United States. Most articles included were dated from the onset of the COVID-19 pandemic in 2020 to 2021, with the exception of two articles which provided a local historical background to the state of SI and loneliness within British Columbia.

During the initial stages of the literature review, the writer attempted to limit the selected research to qualitative or quantitative research studies. This proved problematic for several reasons. First, SI research has largely focused on community-dwelling older adults, rather than those living within LTCFs. Second, the COVID-19 pandemic is a relatively recent worldwide health concern, being declared a worldwide epidemic on March 11, 2020. Thus, research relating

to COVID-19 is newly emerging. Given these challenges, the writer included other types of literature such as letters to the editor, commentaries, and reports from reputable organizations such as the Seniors Advocate of BC and The World Health Organization.

To provide the reader with greater context to this major paper, it should be noted that this was researched and written during the Delta wave of the pandemic, which became the dominant COVID-19 variant in the province of British Columbia, Canada from August, 2021 to mid-December, 2021 (British Columbia Centre for Disease Control, August 6, 2021; British Columbia Centre for Disease Control, December 17, 2021). This was the dominant COVID-19 variant prior to the Omicron variant, and before many countries declared a functional end to the pandemic by ending public health orders (Wadman, 2022, March 4).

Theoretical framework

The theoretical frameworks which guided this literature review are RCT and AOP. RCT was used to explore the concepts of connectivity and relational-cultural paradox in application to SI and loneliness in LTC. AOP was applied to social structures within society that shape the ways in which we care for older adults, leading to the marginalization through the biomedicalization of aging.

Relational Cultural Theory

RCT was created by a collaboration of four female clinicians, Jean Baker Miller, Irene Stiver, Janet Surrey and Judith Jordan, offering a modality which provides strength-based framework to psychotherapy with females (Lenz, 2016). It stands in opposition to a multitude of psychodynamic theories which see human growth across the lifespan as the transition from dependance to independence (Lenz, 2016). Alternatively, Jordan (2018) delineates human growth as occurring toward and through connection with others. Connection provides the

environment necessary to flourish, whereas isolation is a major source of suffering for individuals (Jordan, 2018; Lenz, 2016). Connectivity has been found to ameliorate the impact of stress whereas SI can result in numerous negative health impacts (Hado & Feinberg, 2020). RCT sees disconnection as an inevitable part of human relationships. In instances of disconnection, one individual within the relationship may feel hurt. Where the hurt individual can articulate their feelings and the other individual is able to respond empathetically, then the relationship is strengthened, leading to relational competence (Jordan, 2018; Lenz, 2016). Central relational paradox occurs when the hurt individual is not able to articulate their feelings or that the other person responds with indifference. This results in presenting oneself as inauthentic in order to fit into other available relationships. This can be seen in LTCFs, where residents present their inauthentic selves in order to fit within the preexisting relationships that are available to them, such as with care-aids assigned to LTCRs. These available relationships within LTCFs are limited, due to the lack of opportunity residents have for connection with individuals residing outside of LTCFs. The central relational paradox of LTCRs has been further exacerbated by COVID-19 restrictions. LTCRs have voiced their feelings surrounding restrictive measures to staff members but have faced indifference (Ayalon et al., 2020). These examples demonstrate some of the challenges experienced by LTCRs in maintaining authentic connections. Humans' natural inclination toward interdependence requires a culture that supports connection, rather than a culture which views interdependence as a deficit (Jordan, 2018).

RCT does not propose a unified and linear set of steps for human development. Rather, it suggests that human development is seen through "increasing complexity and articulation within relationships and an increasing capacity for mutuality" (Jordan, 2020, p.6). In prior research, Jordan (2018) proposes five components to growth fostering relationships:

- zest; an increase in energy;
- increased knowledge and clarity about one's own experience, the other person and the relationship;
- creativity and productivity;
- a greater sense of worth; and
- a desire for more connection. (p. 7)

Individuals tend to seek out relationships which are mutual, in that they both give and receive (Jordan, 2018). This is exemplified through SI interventions such as volunteerism, which involve intergenerational mixing, where LTCRs volunteer within schools (Hoffman et al., 2020).

LTCRs experience some challenges participating in growth-fostering relationships. First, LTCRs often encounter difficulties in communication with others due to sensory challenges, such as poor hearing, or cognitive challenges, such as dementia. These communication challenges hinder their ability to understand the other person's experience and their relationship with that person. Another challenge for LTCRs' ability to develop growth fostering relationships is a lack of opportunity to engage in productivity and mutuality. LTCFs are designed to meet most of the care needs for LTCRs, such as having groundskeepers, cleaners or cooks employed. This removes opportunities for mutual contribution or productivity by LTCRs. Isolation and the resulting distress can be seen as a pervasive absence of these within important relationships (Jordan, 2018; Lenz, 2016).

RCT takes a social justice approach, as it believes that disconnection can be created by stratified social organizing and marginalization (Jordan, 2018). Using a RCT lens, it is important to see how the social stratification and marginalization of older adults within LTCFs can create disconnection. LTCRs voice feelings of segregation and isolation, as they are placed into

institutions which have little interface with the outside world (Boahmah et al., 2021). This is one of the unique aspects to RCT, which analyses the impacts of dominance and subordination on groups (Jordan, 2018; Lenz, 2016). Subordination and dominance can be impacted by cultures which value separation and autonomy (Jordan, 2018). Therefore, to approach RCT one must view the individual in relation to the culture in which they live, or that which they are an outsider to. When we examine western society's obsession with youth, we can understand how older adults can become devalued within this culture, resulting in greater chances of disconnection (Chonody & Teater, 2018).

RCT recognizes the construct of controlling images, which are false narratives about social or cultural groups and can affect individual's beliefs of belonging within such groups (Jordan, 2018). Controlling images dictate how individuals and groups should be treated and dictate access to resources and power (Jordan, 2018). The controlling images of older adults were engrained through media representations of LTCRs during COVID-19, depicting older adults as possessing negative characteristics, such as the deterioration of functional and topical capacities of fatality, disease, passivity, dependence and social vulnerability (Bravo-Segal & Villar, 2020). These images influenced the public health orders and restricted LTCRs' access to resources (Ivan et al., 2020). Images such as these can feel real and unyielding, making it difficult for individuals to be authentic against these images (Jordan, 2018). In some cases, individuals absorb these images, becoming part of their relational image and internalized oppression (Jordan, 2018). Shame or feelings of negative self-worth may result, which tends to silence and isolate individuals (Jordan, 2018). One study highlighted that LTCRs experienced feelings of shame due to their perceived SI, attributing negative personal characteristics as causing their isolation (Barbosa-Neves et al., 2019). Therefore, it can be hypothesized that these

negative self-images are perpetuated by ageist stereotypes, such as being a burden or not feeling needed, which are then internalized by residents of LTCFs.

RCT presents great opportunities for research and application in the population of older adults due to the importance of social connection in combatting SI among LTCRs and as there has been limited application of this theory to the older adult population. RCT provides a defined framework for promoting growth-fostering relationships which can assist LTCFs in combatting SI of LTCRs. Ageism permeates all facets of life, therefore it is not unreasonable to hypothesize that it's reach extends to research within older adult populations as well. The application of RCT to the experiences of SI of LTCRs appears to have good compatibility and provides an area for future exploration.

Anti-Oppressive Practice

AOP is a second theoretical framework which has informed the analysis of this paper. AOP focusses on how larger systems uphold power and privilege of one dominant group, whilst leaving others at a disadvantage (Baines, 2017). Disadvantage can take the form of oppression through policies which unjustly impact marginalized groups or by an individual acting unjustly against another individual from a marginalized group (Baines, 2017). AOP draws on a number of different theories that include critical, radical, anti-racist and feminist theories as well as structural social work. AOP and RCT are symbiotic due to their feminist and social justice perspectives and provide a framework to analyze SI among LTCRs during COVID-19.

AOP recognizes that everyday problems are social in nature, shaped by social structures, individual interactions, and those of families and communities (Baines, 2017). Social structures form the ways in which we care for older adults within LTCFs and other aging support services. AOP explores the notion of the biomedicalization of aging. Under this social process, older

adults “are reduced to aging bodies and minds in need of surveillance and treatment by the medical-industrial complex as they degenerate and ultimately fail” (Baines, 2017, p. 194). This perspective configures care for older adults, disregarding holistic approaches to wellness, including aspects such as spirituality, emotional health and social connectivity. Ageism has permeated research and the application of AOP in the field of gerontology, which is an under-studied area. Biomedicalization of older adults also serves to homogenize older adults and services, failing to address the intersectionality and diversity of the older population, resulting in marginalization.

AOP observes the use of language when referring to marginalized groups. Common within the biomedicalization of older adults is medical labelling (Baines, 2017). Medical labelling individualizes and depoliticizes social justice concerns (Baines, 2017). This can be seen in the medical labelling of SI, where proposed solutions are largely recommended at the micro, or individual level. This focus disregards the structural roots of SI among older adults living in LTCFs and perpetuates the marginalization of this population through individual deficit. SI should be more accurately viewed as the result of ageism within societies and is exacerbated by the structural design of institutions, such as LTCFs. Together, RCT and AOP inform the analysis of this literature review on SI among LTCRs during the COVID-19 pandemic.

Long-Term Care and Assisted Living

In Canada, LTCFs are regulated by a patchwork of legislation due to a lack of a nationally-defined comprehensive policy. These facilities are not covered under the *Canada Health Act* (Government of Canada, 2020) as an insurable service, and thus provinces and territories have designed their own systems and regulations. LTCFs within British Columbia are licensed under the *Community Care and Assisted Living Act* (Province of British Columbia: BC

Laws, 2021a) or under the *Hospital Act* (Province of British Columbia: BC Laws, 2021b). Vast differences exist between jurisdictions with respect to the wide range of facilities, methods of payment and regulation, and types of facilities (Armstrong et al., 2009). They can be operated by fully private institutions, by institutions under contract of local health authorities, or by local health authorities.

Within British Columbia, individuals living within LTCFs have complex physical and cognitive care needs, which prevent them from being able to live independently in their own home or an assisted living setting (Province of British Columbia, n.d.). These facilities provide twenty-four-hour supervision and medical care to residents (Province of British Columbia, n.d.). Given the communal setting at these facilities, it can be difficult to understand how LTCRs experience SI; however, the prevalence of loneliness among LTCRs is higher than loneliness experienced by individuals living in communities (World Health Organization, 2021a).

Literature Review

Social Isolation and Loneliness

SI among older adults is a widespread concern among most regions across the globe, such as in Canada, United States of America, Europe and Latin America (World Health Organization, 2021a). From a RCT standpoint, humans are social beings who grow toward and through relationships (Jordan, 2018). This can be demonstrated from our shared past in the context of evolutionary history. In hunter-gatherer societies, humans used to work together in close kinship groups relying on each member's skills and abilities to survive. In the post-industrialized world, we now live in increasingly disconnected lives where SI and loneliness, both social determinates of health, have been neglected (World Health Organization, 2021a).

SI and loneliness, while related concepts, are often erroneously used interchangeably despite their distinct meanings. Loneliness is defined as a painful subjective feeling based upon the quality and quantity of one's social relationships, which are not in alignment with one's desired connections (Boamah et al., 2021; WHO, 2021). SI is an objective measure of the number of social contacts and relationships that an individual has (Boamah et al., 2021; WHO, 2021). Thus, an individual can objectively experience SI but be content with the nature and frequency of social connections they engage in and not experience loneliness. Conversely, an individual can experience loneliness but not meet the objective measure of SI. For the purposes of this literature review, I will be focusing on SI among older adult residents of LTCFs.

What Makes Social Isolation a Health Concern?

SI is an important concern for older adults worldwide, as it contributes to multiple negative health outcomes. Some countries have recognized these health impacts and developed specific approaches to tackle SI, through regional programs and national oversight. One such example is the United Kingdom, who appointed a minister to oversee issues related to SI and loneliness and who developed a national strategy to combat these important concerns. SI has also received multi-national recognition through the World Health Organization (WHO), who propose a three-point global strategy to combat the concern. The WHO is a segment of the United Nations agency, which promotes the worldwide health of all people, though evidence-based science (WHO, 2021b). Thus, national, international and multi-national recognition of the impacts of SI on health has gained recognition and importance throughout the world.

Mental Health Implications. SI has been demonstrated to negatively impact mental health outcomes (Bethell et al., 2021; LeVasseur, 2021). Bethell et al. (2021) found that good social connection is associated with good mental health outcomes. In this scoping review, they

discovered that good social connection was associated with reduced depression, decreased responsive behaviours, better mood, affect and emotion, reduced anxiety and lowered rates of cognitive decline (Bethell, 2021). Instead of looking at social connection and the benefits to mental health, other research has focused on how loneliness and SI negatively impact mental health. Findings demonstrate that loneliness and SI leads to increased depression, increased responsive behaviours, worse mood affect and emotion, increased anxiety and increased cognitive decline (Chu et al., 2020; Day et al., 2020; Harden, 2020).

Physical Health Implications. In addition to mental health impacts, there are many physical health implications to SI and loneliness. SI is linked to premature mortality (Day et al., 2020). It increases the risk of cardiovascular disease, obesity and stroke (Chu et al., 2020; Lively, 2021). Harden et al. (2020) reports that SI is associated with a decreased resistance to infection. Lively (2021) draws a starker association, stating that the health impacts to SI is equivalent to smoking fifteen cigarettes a day. It is also important to understand the bi-directional relationship SI has with chronic health conditions. In other words, SI exacerbates chronic health conditions and vice versa (Barbosa-Neves, 2019; Chu et al, 2020). For example, SI can exacerbate cardiovascular disease and obesity. The negative health implications of SI illustrate the value of social connection to mental and physical well-being.

Risk Factors for Social Isolation of Older Adults in Long-Term Care Facilities

It seems counter-intuitive to view LTCFs as environments where SI occurs. Many of these facilities operate in a communal fashion, housing multiple residents and employing numerous staff to assist in caregiving duties. Despite these opportunities for social interaction and engagement, residents of LTCFs remain at risk of SI. Boamah et al. (2021) sought to identify the risk factors to SI within LTCFs, as much of the research on risk factors has focused on the

community-dwelling population. The authors used a scoping review and identified four broad themes which included predisposing individual factors, LTCF system factors and social determinants of health.

Individual Factors

Boamah et al. (2021) identified individual factors that predispose certain residents to SI, which include communication barriers, such as hearing and cognitive impairment. One of the most critical risk factors to SI is the inability to effectively communicate one's views to others. Communication challenges between care providers and residents leads to less participation and engagement by the resident in social activities that are available within LTCFs. A number of factors can exacerbate or result in communication challenges. Hearing loss experienced by some LTCRs can be aggravated by the physical environment of LTCFs which often have a significant amount of background noise. Hearing impairment acts as a barrier to make meaningful social connections between fellow residents and staff members. Cognitive impairment also proves to be a hindrance to communication, which contributes as a risk factor to SI. Cognitive impairment worsens communication challenges, as information can be mis-heard or misunderstood. This is particularly relevant for those with any form of dementia.

System Factors

System factors, characterized by Boamah et al. as "the location of the LTC facility and availability of staff, the types of services provided including individualized care and autonomy of residents, and the interaction between various aspects of the healthcare system" (2021, p.625) were found to contribute to the risk of SI within LTCFs. LTCRs have been removed from their social and geographic communities and placed within LTCFs, with little integration between the two systems, contributing to a sense of disconnection by residents from their broader

communities (Boamah et al., 2021). In some cases, the geographical location of the LTCF creates a barrier for loved ones to visit residents, thus existing relationships within the community become more difficult to maintain (Boamah et al., 2021). Visitors that are able to attend the LTCF act as a lifeline to the current events in the "outside world," providing information on activities and interactions occurring external to LTCFs (Boamah et al., 2021).

Staff shortages in LTCFs are another systemic challenge that results in a reduction of the quality of care. They cause increased and unsustainable workloads for many LTC staff, lowering the quantity and quality of interactions between staff and LTCRs (Boamah et al., 2021). This has been a preexisting issue within LTCFs before the onset of the pandemic, due in part to BC's low unemployment rate which pushes up wages and puts pressure on low or moderate wage jobs (Office of the Seniors Advocate of BC, 2020). Also implicated within the LTC system is a decrease in resident autonomy through the reliance upon staff members, who are under pressure to follow structured schedules and routines within LTCFs which can further hinder individual choice. Interestingly, this reliance upon staff members and the LTCF leads to a decrease in the resident's social supports which are external to the LTCF (Boamah et al., 2021).

Social Determinants of Health

Social determinants of health are the social and economic factors that impact an individual's health in both positive and negative ways (Canadian Public Health association, n.d.). In their research, Boamah et al. (2021) found that social determinants of health contributed towards SI of LTCRs. LTCFs are products of government and funding institutions which contribute to the "inequities in access to healthcare and resources for the older adults" (Boamah, 2021, p. 626). Social determinants, such as race and economic status, determine one's place within society and can lead to discrimination.

Boamah et al. (2021) identified socio-economic status, sexual orientation and gender identity as social determinants of health which increase risk of SI among LTCRs. Socio-economic status relates to one's social and economic position in relation to others, and is based upon income, occupation and education (American Psychological Association, 2022). This permeates into LTCFs, adding to the stress and vulnerability of SI of LTCRs of low socio-economic status (Boamah et al., 2021). Sexual orientation and gender identity are other determinants impacting SI of LTCRs. The acronym LGBTQ2S+ is an umbrella term used to represent individuals who are lesbian, gay, bisexual, transgender, queer, two-spirit and other identities which are not encapsulated within the acronym. Individuals who identify as LGBTQ2S+ experience unique stress due to the fear of discrimination they may experience. Despite being identified together, there are specific needs and concerns related to an individual's identity. Residents who identify as LGBTQ2S+ experience fear due to the stigma that affects this marginalized group and concern over personal safety. Boamah et al. provided insight into a topic area which has limited research, drawing particular focus into how LTCFs can mitigate SI through planning and operation (2021).

Sociological Perspective

Barbosa-Neves et al. (2019) aimed to explore SI and loneliness within LTC homes from a sociological perspective. The authors engaged in a six-month multi-method study which involved field observation and qualitative interviews of two Australian care homes. They found some parallel results to the Boamah et al. study (2021). One theme the authors defined as "oldering", which is the loneliness experienced by LTCRs due to age related circumstances. Within this theme, the authors included numerous conditions including the reduced capacity to engage with others due to age-related frailty and cognitive health. Additionally, the participants

reported a loss of independence and autonomy over their lives due to institutionalization, which refers to an older adult's transition into a LTCF from a residence outside of this setting. Participants reported the advantages of having frequent staff contact, along with disadvantage of reduced contact with loved ones. These findings mirror those reported in the Boamah et al. (2021) study.

What is unique to the Barbosa-Neves et al. study (2019) is that participants also reported SI to be the result of individual deficits. Participants described that their SI stemmed from introversion, self-imposed choices to remain lonely, personal challenges in developing new social relationships and personal guilt due to their perceived SI. This is an interesting perspective as some participants felt personal fault as causing or perpetuating SI, without the recognition of the environmental context in which they exist. Thus, some participants view SI as stigmatizing and as a private matter, requiring personal agency to solve, despite its structural roots (2019). RCT recognizes that disconnection is not solely a private matter. Environmental contexts impact SI of LTCRs through social stratification, where older adults can become marginalized due to their exclusion from the rest of society through their placement within LTCFs.

Public Health Measures Impacting Social Isolation Among Long-Term Care Residents

In March of 2020, the WHO declared COVID-19 a worldwide pandemic. British Columbia (BC) provincial health officials and the BC Centre for Disease Control responded to the pandemic threat to healthcare workers and LTCRs by implementing policy measures to reduce the risk of disease transmission within this vulnerable population (Office of the Seniors Advocate of British Columbia, 2021, October). Among these aggressive policy measures was the restriction of visitors to LTCFs (Office of the Seniors Advocate of British Columbia, 2021, October). These early and aggressive public health measures were praised by the health

community across the country and assisted to keep BC's outbreaks, cases and deaths in LTCFs lower than in other parts of Canada (Office of the Seniors Advocate of British Columbia, 2021, October). However, these policy measures are not without consequences to residents of LTCFs.

Canadian health authorities have been accused of a failure to plan for the impacts of COVID-19 within LTCFs (Chu, 2021). Planning within LTCFs is particularly important because of the increased susceptibility of LTCRs to the virus due to co-morbidities (Chu, 2021). In addition, what is now understood is that congregate living environments allow for easy transmission of infection, such as in communal dining and group activities which take place in LTCFs (Office of the Seniors Advocate of BC, 2021, October). The high number of deaths within LTCFs led to the strict implementation of public health orders, in attempts to control the infection and transmission of COVID-19 amongst LTCRs. Many of these policies led to an increase in SI among LTCRs.

Visitor Restrictions

The first policy which impacted SI among LTCRs were restrictions to visitors, implemented in BC in March of 2020 (Chu, 2021). The *Canada Health Act* sets a national standard for healthcare in Canada (Government of Canada, 2020). Provinces and territories receive funding from the *Canada Health Transfer* based upon compliance with these standards (Government of Canada, 2020). Due to the provincial responsibility of healthcare in Canada, each province enacted visitor restrictions for varying duration and start dates (Chu, 2021). For example, most provinces implemented visitor restrictions in March of 2020, with the exception of Alberta who implemented visitor restrictions in April of 2020. This discrepancy may be due to the socio-political climates between provinces. The province of Alberta is under the leadership of the United Conservative party, described a "hard-right" political party who has applied a "profits

before lives" pandemic response strategy (Stewart & Jordan, 2021). Additionally, most provinces lifted the constrictive visitor restriction policies after a one-month duration, whereas Ontario's visitor restriction policy remained in place for three months (Chu, 2021). This was likely due to the deterioration of care within LTCFs, resulting from the severe COVID-19 outbreaks and staffing shortages plaguing LTCFs in Ontario in April of 2020. This resulted in the premier of Ontario, Rob Ford, calling on the military to assist. The impacts of visitor restriction policies will be explored in greater depth later in this literature review.

Movement of Staff and Volunteers

Another policy which increased SI among LTCRs was eliminating movement of staff and volunteers within LTCFs (Chu, 2021). Within Canada, LTC staff working for private facilities typically work part-time for multiple locations (Chu et al., 2021; Office of the Seniors Advocate of BC, 2021, October). The public health office of BC put in place the single site order, limiting healthcare staff to work solely at one LTCF, thereby reducing the possibility of infection transmission across multiple LTCFs (Office of the Seniors Advocate of BC, 2021). One of the detrimental consequences to this order is that LTC staff had to make the difficult decision to select one site for employment (Chu et al., 2021). This disrupted the continuity of care experienced by some LTCRs, who no longer saw the LTC staff member with whom they had established a social connection (Chu et al., 2021). RCT views this disconnection as a cause of social suffering and isolation (Jordan, 2018). Under a RCT framework, LTCRs presented their inauthentic selves to fit into the available relationships with unfamiliar staff members, causing their further suffering.

Restricted Activities and Interactions

A third policy which increased SI among LTCRs was the restriction of activities and interactions within LTCFs. In order to promote physical distancing measures within LTCFs, communal dining no longer occurred at one time for each meal of the day. Instead, dining times were staggered or meals were taken inside LTCRs' rooms (Chu et al, 2021). LTCRs were further subjected to restrictions of their movements. They were no longer allowed to leave the LTCF and all external activities were cancelled, essentially isolating residents from the outside world (Chu et al., 2021). LTCRs were relegated to spending time within their rooms, the majority of which are single-occupancy rooms with limited space (Chu et al., 2021; Office of the Seniors advocate of BC, 2021, October).

Views of Long-Term Care Facility Staff

A report by the Seniors Advocate of BC attempted to understand the impacts of COVID-19 preventative measures to LTCFs, LTCRs and staff (2021, October). In their survey of LTC staff, they identified a number of COVID-19 prevention measures which staff believed to be impacting the wellbeing of LTCRs. The following percentage of staff reported that several COVID-19 prevention measures had a very negative or somewhat negative impact on residents:

- eighty-nine percent for visitor restrictions;
- eighty-seven percent for LTCRs' inability to leave the facility for outings;
- eighty-five percent for isolating residents to their room for 14 days when admitted;
- seventy-six percent for dining room limitations;
- seventy-five percent for isolating the residents to their rooms for an outbreak;
- and sixty-nine percent for staff being required to wear medical masks at all times (2021, October, p. 31).

This survey of staff members provides a valuable look into the topic of SI from the unique perspective of staff members. Staff members work in close proximity to and develop relationships with LTCRs. RCT argues that these relationships allow individuals to flourish (Jordan, 2018).

Ageism

Ageism has played a prominent role in the lives and experiences of LTCRs during the COVID-19 pandemic. Ageism is defined as the negative views of aging and older adults, shaped by prejudice, stereotypes and discrimination (Edström, 2018). Ageism is perpetuated through the media, social media and public health announcements by government administrators. During the COVID-19 pandemic, the media has provided extensive coverage of the impacts of the virus on older adults living within LTCFs (Bravo-Segal & Villar, 2020). Older adults have been disproportionally affected by the pandemic for a variety of reasons, not exclusively related to age (Bravo-Segal & Villar, 2020). However, the narrative portrayed by media has largely focused on stereotypes and representations surrounding ageist beliefs, such as frailty (Bravo-Segal & Villar, 2020). These media discourses have far-reaching negative impacts on western society's views of older adults which maintain invisible bias in how western society views SI of LTCRs and how it implements COVID-19 health measures (Bravo-Segal & Villar, 2020).

Media Coverage of Older Adults

Historically, mainstream media has deemed older adults as not being newsworthy, leaving them under-represented (Edström, 2018). However, this invisibility has shifted due to the impacts of COVID-19 on LTCFs. Media has begun to focus its attention on a specific demographic of older adults, those who reside in LTCFs. This coverage has shaped views of older adults and COVID-19 by portrayals of older adults through ageist stereotypes during

COVID-19. Bravo-Segal and Villar (2020) state that one of the issues of media portrayals of older adults is their representation as one homogenous group. This is one example of AOP and the biomedicalization of aging (Baines, 2017). This association of older adults and LTCFs diverges from the diversity of lived experiences of older adults (Ayalon et al., 2020b). In fact, older adults differ in a myriad of ways including health history, life experiences, genetics and cultural backgrounds (Ayalon et al., 2020b). Additionally, older adults who reside in LTCFs account for only three percent of older adults over age 65 (Bravo-Segal & Villar, 2020). This pairing of older adults and LTC within the media serves to perpetuate negative stereotypes of older adults. The false narrative of the homogeneity among older adults are termed controlling images under a RCT lens (Jordan, 2018). Controlling images affect an individual's belief as belonging within this homogenous group, which may result in the individual internalizing this framework into one's identity (Jordan, 2018). Thus, if an older adult is active and is exposed to controlling images, they may internalize an identity belonging to the homogenous group, such as frailty.

In addition to the essentialized representation of older adults, the media generally depicts older adults as possessing negative characteristics, such as the deterioration of functional and topical capacities of fatality, disease, passivity, dependence and social vulnerability (Bravo-Segal & Villar, 2020). These representations are strikingly evident within digital media, where we are presented with visual representations of distorted images of older adults, misrepresenting them in prejudicial ways (Ivan et al., 2020). Some of these images during the COVID-19 pandemic have shown older adults sitting in wheelchairs, holding onto walkers, or confined to beds. Such visual representations, known as visual ageism, reinforce negative characteristics of older adults living within LTCFs (Ivan et al., 2020) and influence policy development for public health measures.

Health Policy

Ageism has permeated the framing, development and implementation of public health policies through the depictions of older adults as frail, dependant and vulnerable (Ivan et al., 2020). Some of these ageist depictions of older adults include dependance, vulnerability and deterioration of health (Ayalon et al., 2020b). From an AOP lens, this process is referred to as the biomedicalization of aging, where older adults are reduced to their aging bodies, which frames the medical care provided to older adults (Baines, 2017). Ageism is evident by some medical practice decisions which solely utilized age as a criterion for treatments in resource-scarce situations, such as in the use of ventilators (Bravo-Segal & Villar, 2020). For example, the United States of America has adopted the Ventilator Allocation Guidelines where age can be used as a 'tie-breaking' criterion (Fraser et al., 2020). This example demonstrates the devaluing of older adults in medical policy decisions (Bravo-Segal & Villar, 2020). Another example of ageism in policy decisions is in countries whose healthcare systems have become overwhelmed with patients, where patients become prioritized by their chances of survival (D'cruz & Banarjee, 2020). A further example of these discriminatory practices is the proposals of protracted lockdown measures for older adults by some health authorities, framed as being for the older adult's own protection (Bravo-Segal & Villar, 2020; D'cruz & Banarjee, 2020). This measure has been rationalized as a necessary sacrifice by older adults to prevent overwhelming the healthcare system (D'cruz & Banarjee, 2020). However, this example provides a false notion that chronological age should be the main criterion for risk during the COVID-19 pandemic, as opposed to other risk factors such as health history, chronic conditions, or lifestyle (Fraser et al., 2020). In fact, data has shown that "younger adults represent the largest proportion of COVID-19 carriers" (Fraser et al., 2020, para. 5). Therefore, public health measures to stop the spread of

COVID-19 should focus on younger adults as opposed to restricting freedoms of older adults to minimize risk of infection.

False Binary

Ageism during the COVID-19 pandemic also serves to polarize a false binary of older adult versus young person (Ayalon et al., 2020b). During the early stages of the pandemic, there have been reports of individuals expressing relief that the majority of individuals dying are older adults (Berg-Weger & Morley, 2020). Current public discourse influences public policy, which suggests protecting older adults by enclosing them in LTCFs for their own protection (Ayalon et al., 2020b). Public discourses which emphasize susceptibility to the negative effects of COVID-19 due to age permit younger people to direct anger and resentment toward older adults (Ayalon et al., 2020b). Additionally, this discourse emboldens younger people to engage in risky behaviours which increase their chances of also contracting COVID-19 (Ayalon et al., 2020b). The negative portrayals of older adults, coupled with the polarizing nature of the young and old may cause young people to internalize these negative beliefs of aging and health (Ayalon et al., 2020b).

Paternalism

In addition to the impacts of ageism on policy design and implementation, ageism reinforces paternalism by excluding older adults from policy development. This paternalistic stance in policy has also been demonstrated in the exclusion of visitors from LTCFs as part of public health emergency measures (Tupper et al., 2020). Paternalism is also evidenced by the lack of autonomy within LTCFs, and the surveillance experienced by LTCRs from staff members. The carte-blanche implementation of this policy has shown a lack of insight into who

are deemed visitors and what roles they play within LTCFs. Many of these visitors are individuals who provide day-to-day care for their loved ones, accounting for up to thirty percent of care needs for residents living within LTCFs (Tupper et al., 2020). The restriction of such visitors resulted in poorer resident health outcomes within LTCFs (Tupper et al., 2020). More recently, the policy has been amended to allow individuals to be labelled as essential caregivers on a case-by-case basis, which was determined according to different LTCF policies who made up their own criteria, thereby providing access to these designated individuals within LTCFs. These amendments demonstrate a recognition of the challenges this restrictive policy posed for LTCRs, their loved ones and LTC staff members. Additionally, the amendments reveal consequences of the implementation of carte-blanche policy without the incorporation of LTCRs' voices in policy development. Despite its relatively recent emergence, the themes of paternalism that guided the development of such policies suggest that ageism has taken a foothold in western society.

Family Caregivers Mis-characterized as Visitors

In March of 2020, visitors were restricted from LTCFs in BC, except for those falling under "compassionate care" and family support. Compassionate care visits were defined as visits which would fall under the category of medical assistance in dying, critical illness, end of life, palliative and hospice care (Hou & Wong, 2021). Family support visits were granted at the discretion of the Health Authority and LTC administration where family members had routinely provided feeding, mobility, or communication support to the LTCRs (Hou & Wong, 2021). Initially, these exemptions were argued to lack clarity and be inconsistently defined (Tupper et al., 2020). These visitor restrictions resulted in a significant reduction in the number of visitors attending LTCFs and attending to LTCRs.

Support Social Connection

Family caregivers are often key partners to the quality of care received by LTCRs and serve key roles in the lives of residents (Hado & Feinberg, 2020; Tupper et al., 2020). First, family members support important social connection for LTCRs. Their mental well-being is supported by family members, who encourage participation in social connection through participation in activities, including those outside of LTCFs (Hou & Wong, 2021). Many residents of LTCFs who experience SI have come to depend on family visits (Gardner, 2020). Gardner argues that these visits prevent LTCRs from feeling lonely, abandoned and despondent (2020). Since visitor restrictions were put in place, LTCRs and their family members have expressed concerns over SI (Hou & Wong, 2021) as LTCRs grieve over the loss of companionship of family members during visitor restrictions (Tupper et al., 2020).

Provide for Care Needs

Family members play a vital role as caregivers to LTCRs, which is unseen and unrecognized (Hou & Wong, 2021; Tupper et al., 2020). Tupper et al. (2020) states that thirty percent of all care to LTCRs is provided by family members. Care can be defined as "feeding, washing, toileting, social, emotional and memory support, and mobilization" (Tupper et al., 2020, p335). Two studies explicitly clarify the role of family members as assisting in the activities of daily living of LTCRs (Hou & Wong, 2021; Hindmarch et al., 2021). Activities of daily living is a term used by health professionals to describe the self-care tasks that an individual or care team performs daily, which are fundamental in caring for an individual and include such activities as personal hygiene, toileting, bathing, transferring, grooming and dressing. In contrast to these functional activities, social and emotional care includes the time that family members spend assisting LTCRs in these activities (Hou & Wong, 2021). As family

members were no longer able to assist in the activities of daily living for LTCRs, this contributed to an increase in workload for LTC staff (Hou & Wong, 2021). The increase in workload was further compounded by staffing shortages, caused by an additional provincial health policy called the single site order (Ayalon et al., 2020a; Office of the Seniors Advocate of BC, 2021). Prior to the onset of the pandemic, many LTCFs already struggled to maintain adequate staffing levels (Ayalon et al., 2020a). In a confidential survey to staff working at LTCFs in BC, seventy-five percent reported working short-staffed within the past year (Office of the Seniors Advocate of BC, 2021). Thus, the increased workload for staff, brought on by the single site order and the lack of family caregiver assistance, may have added to a deterioration of care for LTCRs and reduced social connection.

Monitor Quality of Care

Family members monitor quality of care for LTCRs (Gardner, 2020; Hado & Feinberg, 2020; Tupper et al., 2020), serving as important advocates for the care of LTCRs within LTCFs (Hindmarch, 2021). When family members are not present, they are not able to assist in the care needs of LTCRs nor are they able to alert staff to potential problems in the care of LTCRs (Tupper et al., 2020). As such, the presence of family in LTCFs also serves to prevent resident's vulnerability to abuse and neglect (Gardner, 2020; Miller, 2020), by facilitating communication and improving quality of life. Mortality is reduced and quality of life is improved with the presence of family members in LTCFs.

Facilitate Communication

Family members facilitate communication between LTCRs and staff (Hou & Wong, 2021; Tupper et al., 2020). They act as interpreters for LTCRs who are not competent in the official language. Facilitation of communication is especially relevant for individuals with

cognitive impairment, as family members bridge past memories with the present for LTCRs living with dementia and assist LTCRs in understanding their daily lives (Hou & Wong, 2021). As previously identified in a study by Boamah et al. (2021), communication is a risk factor for SI among LTCRs. Communication is also facilitated by family members through the discussion of issues that require shared decision making, such as in care plans, and instances where family members become defacto decision makers when the LTCRs no longer possess the capability to make important decisions on their own (Hado & Feinberg, 2020).

Given the vital role that family members provide to LTCRs in maintaining residents' health and wellness, it has been argued that family members have been mis-characterized as entertaining visitors (Tupper et al., 2020). Despite their caregiving duties being relied upon by LTC institutions, they are unrecognized in a patient-centred system and are inconsistently consulted in the circle of care (Tupper et al., 2020). Family members play a vital role in the practical aspects of caregiving to LTCRs, but also contribute to the LTCRs' social connection through these tasks. Visitor restrictions caused deleterious effects on LTCRs communication with LTC staff and other residents, thereby increasing SI.

Reduced Access to Healthcare

One of the negative impacts to residents' experience within LTCFs during COVID-19 is the restricted access to medical care (D'cruz & Banerjee, 2020; Harden et al., 2020; Hoffman et al., 2020; Lively, 2021). LTCFs provide a range of services in areas such as social, personal and healthcare needs to meet the needs of LTCRs (Ayalon et al., 2020b). This includes in-patient medical treatment and rehabilitation services (Ayalon et al., 2020b). Individuals who reside in LTCFs have complex healthcare needs, frailty, comorbidities and compromised immune systems (Office of the Seniors Advocate of British Columbia, 2021,

October). COVID-19 has impacted the accessibility of medical services to those living in LTCFs due to the transition from in-person medical to telephone or virtual appointments, resulting in a decrease in the quality of management of chronic conditions and preventative care as a result of a lack of access to or an inability to use technology (Lively, 2021). The shift to virtual healthcare visits also caused challenges in developing personalized care to LTCRs, impacting the quality, patient-centred, holistic aspects of LTCRs' care plans (Harden et al., 2021). As advocates were removed and support structures altered, LTCRs were at a higher risk of negative health outcomes (Harden et al., 2021). Additionally, healthcare resources for the elderly which have been deemed non-essential have been reallocated towards the pandemic (D'cruz & Banargee, 2020). Some of the reallocated services include counselling, physiotherapy, elective surgeries, hearing aids, visual aids, training for neurocognitive disorders, occupational therapy and palliative care.

D'cruz and Banargee (2020) recognize that restricted access to medical and healthcare resources for those in LTCFs is not necessarily a new phenomenon, although the pandemic has exacerbated this concern. The authors state that ageism has always played a role in the allocation of healthcare resources and medical appointments. Older adults experience structural exclusion from healthcare. Neurogenerative disease and mental health concerns are erroneously normalized as part of the aging process. Aside from these longstanding ageist impacts to healthcare, D'cruz and Banargee (2020) state that what is novel to the pandemic situation appears to be a healthcare triage system which places lower priority placed upon older infected adults. This highlights ageism of LTCRs as a pervasive and ongoing challenge to the healthcare of older adults.

Ethics

When working with vulnerable populations in institutional settings, ethical considerations are paramount to ensuring LTCRs are treated justly and with integrity. AOP provides a social

justice lens in which to view ethics, with the purpose of reducing marginalization of older adults. The COVID-19 pandemic has caused an examination of the ethics of some policies and practices intended to preserve life of LTCRs, but instead resulted in marginalization and a reduced quality of life.

Autonomy

Autonomy within LTCF settings is important to self-worth, dignity and personhood (Smebye et al., 2016). During the COVID-19 pandemic, LTCRs experienced a lack of autonomy (Ayalon et al. 2020a; D'cruz & Banerjee, 2020; LeVasseur, 2021). Traditionally, LTCFs care for residents who are dependent on others for tasks such as managing finances and basic activities of daily living. People with disabilities and whom rely on others for their care, do so for a longer period of time due to increased life expectancies (D'cruz & Banerjee, 2020). Many of these individuals are cared for in LTCFs which are equipped to manage their complex healthcare needs. According to Statistics Canada, seven-point one percent of older adults aged sixty-five and over lived in collective dwelling environments, such as LTCFs and other residences for older adults which provide specialized care (2018). Residents of LTCFs are at risk of experiencing an existing lack of choice and autonomy in their lives due to the structured nature of these facilities in how they operate and care for residents. D'cruz and Banerjee (2020) comment on the lack of choice given to older adults, due to marginalization. As a result of their vulnerability to the COVID-19 virus, infection control measures were more stringently applied to older adults living in LTCFs than in other settings such as schools (D'cruz & Banerjee, 2020). Public Health Authorities and staff of LTCFs became decision makers, depriving residents of LTCFs of their autonomy, agency and independence to make health decisions for themselves (D'cruz &

Banerjee, 2020). Public health and staff members at LTCFs took a paternalistic stance in this regard, attempting to make decisions for the well-being of others.

Ayalon et al. (2020a) compared the degree of autonomy experienced by LTCRs and the autonomy of other older adults living within the community. In the initial presence of COVID-19 in BC, public health measures were implemented broadly across all facets of society, with stay-at-home orders in effect. Older adults living in the community benefited from the freedom of autonomy and choice to abide by or disobey these public health measures (Ayalon et al., 2020a). In contrast, LTCRs were deprived of this autonomy. Management of LTCFs informed residents of how they could conduct themselves and engaged in surveillance of their actions (Ayalon et al., 2020a). This illustrates the discrepancy experienced between LTCRs and older adults living within the community.

Surveillance of Long-Term Care Residents

Surveillance of LTCRs was easily accomplished, given the institutional setting of LTCFs (Ayalon et al., 2020a). Due to the surveillance of LTCFs, they can easily become "totalitarian institutions in which the residents have minimal opportunities to exert their will" (Ayalon, 2020a, p.1240). LTCFs are designed in a way to encourage communal living (Ayalon et al., 2020a). Additionally, rooms within LTCFs tend to be smaller in order to encourage interaction between residents and staff in communal spaces (Ayalon et al., 2020a). Often, these rooms are shared between LTCRs, which is a concern from an infection transmission standpoint (Ayalon et al., 2020a). The review of COVID-19 outbreaks in BC report conducted by the Seniors Advocate of BC found that there is a twenty-four percent higher risk of larger COVID-19 outbreaks within LTCFs with shared rooms than in facilities with single-occupant rooms (2021). Therefore, the physical structure and design of LTCFs made surveillance by staff members easier to

accomplish, but also enabled disease transmission. Surveillance in LTCFs is an example of the AOP concept of the biomedicalization of aging, which describes the social practice where "older adults are reduced to aging bodies and minds in need of surveillance and treatment" (Baines, 2017, p. 194).

Individual Versus Collective Rights

Research also focused on the ethics of the public health orders affecting LTCRs. One such study by LeVasseur (2021) compared the rights of the individual to those of the group. LeVasseur (2021) took a unique approach to understanding the effects of SI of LTCRs during COVID-19 by using a case report. The author described the case of a LTCR living with dementia. Pre-pandemic, this resident benefited from daily visitors at the LTCF in which she lived. With visitor restrictions, this individual began to experience negative health impacts, including worsening depression, cognitive decline, and weight loss, despite the online visits with family which were facilitated. In spite of the supplements to her diet, the LTCR lost 14.4 pounds over the course of six months. A patient health questionnaire which screens for depression, found that the resident decreased from a score of 5 indicating mild depression to 12 indicating moderate depression. Finally, a brief mental status report of the resident declined from 9 to 0, moving from mild to severe cognitive impairment. Family members recognized the LTCRs' deterioration in cognition, worsening depression and weight loss, and made requests to the LTCF for in-person meetings which were denied. Sadly, the resident suffered a life-ending stroke. In the analysis of the case report, LeVasseur (2021) concludes that "the ethical perspective of the pandemic is to protect the population as a whole, including those living in LTCFs" (p. 781). In other words, the author rationalized the death of the participant as the need to prioritize the safety of all the LTCRs over the safety needs of one resident (2021).

The ethical rationalization which is evident in the LeVasseur study (2021) originates from a public healthcare standpoint where collective interests are given precedence, which is differentiated from how traditional healthcare operates (Swiffen, 2020). The mission of public healthcare during a pandemic is to break the chain of infection transmission in a community. It involves a myriad of stakeholders with broad scope. This mandate contrasts from that of traditional healthcare, which is typically viewed as an interaction between an individual and healthcare professional, using a patient-centred approach. Caselaw surrounding the application of the Canadian Charter of Rights and Freedoms within public health emergencies is negligible; however, there is a proclivity for the courts to protect public health by limiting individual rights. Swiffen (2020) advises that there are concerns of establishing precedent in deference of individual rights in favor of collective interests. This is evidenced by LeVasseur's (2021) case report, which reflects the challenges of public health policy on those living with dementia in LTCFs.

Bioethics

Lively (2021) presents a bioethical analysis of policies relating to SI among LTCRs, stating that there were severe limitations to the liberty of those living within LTCFs. Within the research article, the author reflects on five points: harm and proportionality; reciprocity; transparency by government, the media and LTCFs; autonomy, beneficence and non-maleficence and finally justice.

Harm and Proportionality. Harm and proportionality should be revisited at multiple points during the pandemic (Lively, 2021). LTCRs are at increased risk for infection of COVID-19, requiring hospitalization and possibly leading to mortality. At the onset of the pandemic, there was uncertainty of the COVID-19 virus and confusion which justified the public health

measures put in place at LTCFs, such as the restriction of visitors, activities, social interactions, and movement of staff and volunteers. Lively argues that as the pandemic continued and the restrictions became protracted, there were risks of harm to individuals by these restrictions. Ongoing evaluation and analysis of these restrictions should be done to consider whether less restrictive measures could have been implemented sooner (Lively, 2021).

Reciprocity. Reciprocity "is a core principle of public health and requires the balancing of the benefits and burdens of the social cooperation" (Lively, 2021, p. 4). Under this principle, if one sacrifices their personal liberties for the greater good of others, society then owes a reciprocal obligation to the individual (Lively, 2021). This obligation could include providing support or refraining from discrimination which is perpetuated towards the individual. Within the context of LTCFs, residents had their autonomy taken from them through lockdown measures, among others (Ayalon et al. 2020a; D'cruz & Banerjee, 2020; LeVasseur, 2021). This protected both the LTCR from infection, but also greater society as they attempted to keep healthcare systems from being overrun and preserve medical supplies (D'cruz & Banarjee, 2020). Society recognizes that older adults who become infected with COVID-19 would require greater medical resources. Lively (2021) poses the question, what does society owe residents of LTCFs for their sacrifice of personal liberties? Perhaps, it is to research the effects of public health restrictions on residents of LTCFs (Lively, 2021).

Transparency of Government, the Media and Long-Term Care Facilities. Information from public health authorities, media and LTCFs was limited and unclear, variable or included misinformation which left room for individuals to speculate, question and doubt this correspondence (Hindmarch et al., 2021; Lively, 2021; Tupper et al., 2020). Media presented information which was misleading and fear-invoking, and LTCF pandemic plans and

infection control activities were not communicated in a timely and clear fashion (Tupper et al., 2020). Several studies took note of the communication challenges between LTCFs and family members, at a time when these family members were impacted by visitor restrictions to LTCFs. Family members of LTCRs were frustrated by a lack of information provided by the LTCFs about their loved one (Tupper et al., 2020). Hindmarch et al. (2021) echoed this finding; family caregivers were irritated by the variable communication they received about LTCRs during visitor lockdowns. One family caregiver explained that when she did receive correspondence, typically it would not contain valuable information. Instead, staff members would often state that "she is doing fine today, she is being cooperative" (Hindmarch et al., 2020, p. 197). Aside from confusion, a further consequence to inconsistent communication to family members includes noncompliance of infection control procedures (Chu et al., 2021). Infection control policies at LTCFs changed frequently, as a result of directives from public health orders, which challenged LTCFs' ability to provide consistent communication to family members (Chu et al., 2021). Harden et al. (2020) found that impaired communication was one of the most significant issues affecting family of LTCRs, which comprised of LTCRs being unable to communicate with their family supports and miscommunication between LTC staff and family. Impaired communication led to increased levels of stress and frustration for family members and LTCRs (Harden et al., 2020). Family members play a critical role in the health and well-being of LTCRs. Visitor restrictions, coupled with the variable communication received by family members of LTCRs resulted in a disconnection of their role as family caregivers and caused significant stress to both family members and LTCRs. Given the key role that family members have in LTCRs' wellness, it is critically important that

communication channels remain open between government officials and LTC providers, LTC staff and family members (Miller, 2020).

The Balancing of Autonomy, Beneficence and Non-maleficence. Lively (2021) explains that the initial public health orders were in conflict with LTCRs' autonomy. These restrictions resulted in some beneficence to the LTCR, which was a decrease in the possibility of becoming infected with COVID-19. In medical ethics, beneficence is the moral duty of a practitioner to act in a patient's self-interest. As a result of these public health orders, Lively (2021) asserts that LTCRs also encountered negative physical and emotional effects. Thus, in the protection of the health of LTCRs, there also was an associated harm. Lively argues that the prolonged restrictions on LTCFs became maleficent, which is a medical ethics term for 'cause harm' (2021). Maleficence can be caused through the neglect of a patient, such as with the social distancing policies causing LTCRs to experience SI. Older adults should be included as stakeholders in policy making, as they are not passive recipients of care in a system which treats them paternalistically (D'cruz & Banargee, 2021; Lively, 2021; Tupper et al., 2020).

Justice. When one examines justice, one must scrutinize any discrepancies or special protections that exist between LTCRs and their older adult counterparts living independently in the community (Lively, 2021). Stay at home orders did not result in the equal treatment between these two groups. Rather, LTCRs were forced to remain isolated in the facility, thus experiencing greater depression due to the surveillance and lack of choice in abiding by the public health orders. In the article, Lively introduces Kant's categorical imperative, which argues that "selectively restricting older adults for the good of other people amounts to treating older adults as a means to an end for others" (Lively, 2021, p. 5). In other words, older adult's autonomy is sacrificed to ensure that scarce medical resources are available to younger

individuals and those living in the community. This same sentiment was found by D'cruz and Banerjee (2021), where older adults were expected to sacrifice themselves for the greater good of society. In the article by Lively, Kant's categorical imperative is applied to LTC restrictions (2021). Individual residents are protected from infection by the public health restrictions imposed. However, the restrictions create an imposition on residents to serve the larger population through safeguarding of scarce medical resources. Lively argues that this treats LTCRs as a means to an end for residents living within the community (2021). Due to the isolation of LTCRs and their decreased need of medical supplies, these supplies would then be available to residents living within the community (2021). Kant's overarching principle is to maintain dignity, thus public health orders should be viewed in relation to their impact on dignity of a person, recognizing the value and equal worth that LTCRs possess (2021). Lively concludes the article by advocating for balancing the need of public health orders to the potential of harm that the health orders enact on those affected (2021).

Quality Versus Quantity of Life

One of the final ethical topics that emerged from the literature is policies which focus on the quantity of life versus the quality of life (Chu et al., 2020). Chu argues that autonomy versus the individual acceptance of risk has received very little regard within society. Morbidity should be viewed with the same level of importance as mortality. LTCRs and their families should be given some freedom to make decisions which impact their wellbeing. Some residents drew stark comparisons of their experiences in LTC during the public health measures as being a captive. In some cases, LTCRs favored death over isolation in their rooms. One consequence to the unknown duration of public health isolation measures has resulted in some LTCRs not having in-person visits for months or years before their deaths (Chu et al.,

2020). In a study by Ayalon et al. (2020a), some LTCRs expressed fear of dying in isolation during the COVID-19 pandemic. The authors argue that care plans should consider not only physical health, but also psychosocial wellbeing of LTCRs (Ayalon et al., 2020a) towards greater autonomy and quality of life.

Social Isolation May Lead to Greater Susceptibility to Infection if Exposed to COVID-19

An interesting research article by Cohen (2020) hypothesized that isolating in homes contributes to greater vulnerability to infection and disease if exposed to COVID-19. Cohen (2020) has engaged in viral-challenge research which looks at psychosocial factors which determine who may become ill when exposed to a virus which impacts the upper respiratory tract. They found that individuals with higher levels of stress were more susceptible to upper respiratory disease. SI can be viewed as a psychosocial stressor. The authors sampled 276 participants who reported their level of social connection. Social connection is known to predict lesser mortality and is associated with a lowered risk for cardiovascular disease and disease progression. These participants were exposed to an upper respiratory tract virus. The author found that those who were least socially connected were 4.2 times more likely to develop a cold than those who were more socially connected. Perceived social support, defined as the "resources provided by one's social network in the face of adversity, has also been hypothesized to protect against the pathogenic effects of stress" (p. 169). COVID-19 is similar to the common cold or influenza, in that it affects the upper respiratory tract. Thus, the authors hypothesize that public health orders instructing individuals to stay at home may increase one's chances for contracting COVID-19 if they are exposed to the virus. This hypothesis makes a strong argument for the deleterious effects of stay-at-home orders and resulting SI among LTCRs. Cohen (2020)

suggests that this may help to focus public health resources and interventions for individuals deemed high-risk, if exposed to the virus.

Implications for Practice: Proposed Solutions to Combat Social Isolation Within Long-Term Care Facilities

Micro-Level Interventions

Due to the strict public health orders, residents of LTCFs have experienced negative impacts to their health and wellbeing, in addition to increased SI. These orders should not prevent LTCRs from maintaining social connections with family members and loved ones (Hado & Feinberg, 2020). In fact, the uncertainty, stress and vulnerability experienced during the COVID-19 pandemic by LTCRs should make social connectivity a priority for LTCRs (Hado & Feinberg, 2020). At the micro level, several interventions have been recommended to maintain social connectivity between LTCRs and their loved ones and maintain LTCRs' health and wellbeing. Micro-level interventions include improving communication through the development of a communication strategy and the employment of students, use of technology and better access to telehealth, staff support of social interactions and the increased monitoring and assessment of SI of LTCRs.

Communication Strategy

Improving communication between LTCFs and family members through a communication strategy was identified as one of the prominent solutions to reduce SI among LTCFs (Hado & Feinberg, 2020; Tupper et al., 2020). Hado and Feinberg (2020) and Tupper et al. (2020) suggest that LTCFs should be mandated to inform LTCR families and loved ones of their care, including developing a communication strategy between LTC staff and key family representatives. Staff members could be assigned as a primary contact to family members or

loved ones in order to bolster communication between LTCFs and family members or loved ones. Some key topics that might be addressed during these communications include treatment options and implementing advanced care plans, which are guidelines for future healthcare decisions when a patient is no longer able to make these decisions alone. Another intervention to support communication between LTCFs and family members is to attempt to mobilize students and trainees in these tasks, such as gerontological social work students. The BC Seniors Advocate found that 80% of LTCFs surveyed reported a significant increase in workload related to communication with families during the COVID-19 pandemic (Office of the Seniors Advocate of British Columbia, 2021). Students would assist in supporting LTCFs staff who are burdened by heavy workloads. These students could share infection control policies within LTCFs, support families and loved ones by contacting them regularly to inform them of the wellbeing of the LTCR (Hado & Feinberg, 2020). Tupper et al. (2021) made similar recommendations, suggesting the possibility of increasing, repurposing or reallocating staff to facilitate communication between LTCFs and loved ones. Information sharing between LTCFs and LTCRs' family and loved ones would allow for families to continue their advocacy efforts to ensure the health and social connection needs of the LTCR were met.

Technology

The use of technology can assist LTCRs in maintaining social connection during the pandemic, and include the use of social media, telephone and video conferencing (Bethell et al., 2021; Chu et al., 2021; Day et al., 2020; Hado & Feinberg; Hoffman et al., 2020; LeVasseur, 2021). Another example of technology being used by families are web-enabled cameras, also known as granny-cams (Chu et al., 2021). These allow families to monitor their loved ones through video and audio communication (Chu et al., 2021).

Technology-based interventions have become an important tool during the COVID-19 pandemic, as physical distancing was recommended in order to reduce the possibility of COVID-19 transmission. The regular use of videoconferencing between LTCRs and family members has been demonstrated to have beneficial impacts on social support and loneliness (Bethell et al., 2021). Technology remains an important tool for LTCRs to maintain social connections with their loved ones.

The use of technology to facilitate social connection of LTCRs presents some challenges including accessibility and useability. Accessibility to devices, such as computers, tablets and smartphones, remains a concern within LTCFs (Hoffman et al., 2020). Many LTCFs have a limited number of tablets which are to be shared amongst many LTCRs (Chu et al., 2020). Thus, attempts should be made to bridge the gap by funding these devices through medical insurance, such as the provincial health Medical Services Plan (Hoffman et al., 2020). The University of British Columbia (UBC) attempted to ameliorate SI of LTC residents through an initiative called Connecting for Compassion (Hou & Wong, 2021). This program allowed residents to connect to loved ones, as well as student volunteers and the UBC school of dance, by providing Ipads with videoconferencing programs to LTCFs (Hou & Wong, 2021). Another technological challenge is that some LTCRs lack the dexterity required to hold a tablet, resulting in family members viewing the ceiling as opposed to the LTCRs' face (Chu et al., 2020). Individuals with functional limitations in using these technologies should be provided with additional support (Hoffman, 2020), which in some cases has been provided by LTCFs who have hired additional staff to support LTCRs' technology use (Chu et al., 2020). Some LTCRs lack the digital skills required to use technology and therefore educational opportunities might be advantageous for usability of technology devices (Berg-Weger & Morley, 2020; Day et al., 2020). Chu et al. (2020) proposes

that technology is not designed for the capabilities of older adults and requires improvements to create user-friendly applications for older adults. The authors suggest a need for collaboration between technology developers, researchers, older adults and their family members to come up with innovative technology design that would be user-friendly for older adults (2020).

Campbell presented an alternative view to the use of technology within LTCFs (2020). The author argues that a critical component of social connectivity involves physicality, where "sharing physical space and touch is a valuable feature of relationships with family and friends, with connection and love often expressed through eye contact, handshakes, hugs, or other forms of physical expression" (Campbell, 2020, p. 669). Despite technology assisting in maintaining social connection, the quality of these interactions is reduced due to the lack of physicality of the interaction. This is particularly ubiquitous for individuals experiencing cognitive decline or communication impairments who rely on physicality to communicate with others.

Technology has also become a new avenue for providing services to individuals within LTC, such as in healthcare (Day et al., 2020). Telehealth has become normalized, consisting of both telephone and video appointments (Day et al., 2020). It facilitates access to healthcare, where previously residents would have to be transported to a doctor's office or admitted to hospital. Additional benefits to telehealth programs are that they reduce cost and time. Telehealth allows residents to maintain some continuity of healthcare during the pandemic.

Staff Support of Social Interactions

In addition to technology, LTCFs can assist in maintaining and supporting safe social interactions (Chu et al., 2021). These relationships include between staff-resident, family-resident and resident-resident interactions. One example of supporting resident to resident interactions is with the relocation of LTCRs to rooms which are in proximity to friends, whom

they might not normally see unless engaging in a group activity. In supporting family to resident interactions, Switzerland installed a “visitors box” outside of the LTCFs. This allowed for a safe space for visitation between family member and LTCR which followed local infection control policies (Chu et al., 2021). Solutions such as these might not always be possible, but are a creative way to maintain social connection of LTCRs.

Monitoring and Assessment of Social Isolation

A final strategy suggested to mitigate the effects of SI on LTCRs is increased monitoring and assessment. Chu et al. (2021) suggests that standardized tools should be used by staff in order to inform clinicians and family members of wellness declines and assist in selecting appropriate interventions. These tools could be used to compare declines in SI across multiple jurisdictions, thereby identifying patterns and identifying the impacts of policies affecting SI. Berg-Weger and Morely (2021) also propose using SI and loneliness assessment tools which can be administered quickly and easily, so as to decrease the burden of extra workload for LTC staff. The authors are awaiting psychometric validation for an assessment tool they have developed called the ALONE scale; however, other scales are available to measure SI and loneliness. One example question from the three item UCLA loneliness scale is ‘how often do you feel that you lack companionship: Hardly ever (1), some of the time (2), or often (3)?’ (National Academies for Sciences, Engineering and Medicine, 2020, p. 111). These tools might encourage staff members to ask about these experiences, which is rarely done (Berg-Weger & Morley, 2021).

Mezzo-Level Interventions

One intervention at the mezzo level which would address SI in LTCRs includes the development of evidence-based group interventions, such as Circle of Friends (Berg-Weger & Morley, 2021). Developed by the Helsinki University, this intervention involves weekly group

sessions with LTCRs incorporating a number of topics such as exercise and health content, art and other inspiring activities. Some of the positive outcomes identified by the Circle of Friends intervention include decreases in healthcare costs, SI and loneliness, and increases in wellbeing. Berg-Weger and Morley (2021) emphasize the importance in combatting SI and loneliness as a result of the pandemic, using innovative methods through the collaboration of interprofessional teams.

Day et al. (2020) propose other group interventions that target specific needs of LTCRs, deliver psychoeducational components and/or provide avenues for social connection through activities. For instance, LTCRs can be susceptible to chronic wounds, such as venous leg ulcers, due to the natural slowing of healing that accompanies older age. Given the impacts of chronic wounds on quality of life and the need for social connection, Day et al. (2020) suggest a leg club. Groups such as these "emphasizes the importance of wellbeing, social interaction, health promotion and education, delivering treatment in a non-clinical setting" (Day et al., 2020, p. 57). These types of clubs are flexible, tailored to the needs of the community, and are in partnership with volunteers and clinicians, whilst promoting social connection among members (Day et al., 2020). These innovate group interventions would require some tailoring to comply with local public health measures during the COVID-19 pandemic.

Two other possible interventions to combat SI include letter writing campaigns and intergenerational mixing. Letter writing campaigns typically involve volunteers who writer letters and include such things as poetry, inspirational messages and photographs to LTCRs. The aim for letter writing campaigns is to remind LTCRs that they are valued. Intergenerational programs have bidirectional benefits both for LTCRs and younger individuals (Hoffman et al., 2020). They include relationship building and social connectivity, improving younger

generations' positive behaviors and beliefs towards aging, and older adult cognition and functioning (Hoffman et al., 2020). Some programs involve younger generations providing companionship to older adults, caregiver respite, as well as LTCRs volunteering in schools (Hoffman et al., 2020). Intergenerational mixing also facilitates LTCRs' connection to life outside of LTCFs (Day et al., 2020). Taken to a structural level, intergenerational mixing can include the planned co-location of preschool and LTCFs (Day et al., 2020).

Macro-Level Interventions

SI and loneliness have come to the attention of the WHO, who report between 20 and 34% of older adults in China, Europe, Latin America and the United States of America experience SI (World Health Organization, 2021a). They devised a three-point strategy to combat SI and loneliness on a global scale. The first recommendation is to create a global coalition on SI and loneliness in order to increase awareness of the topic and make it a political priority. The aim is to bring about financial resources and human expertise to match the level of severity that is warranted on this topic. The next strategy is to address the research gaps of SI and loneliness, with a focus on identifying effective interventions to SI and loneliness. This includes the development of a standardized tool to measure SI and loneliness, which is absent from existing practice. The final strategy is to implement targeted and multi-faceted interventions involving multiple stakeholders and sectors. It includes laws and policies addressing discrimination and marginalization based upon age, promote social cohesion and intergenerational solidarity. This blanketed approach prescribed by the WHO is similar to that which has been advocated by Day et al. (2020). The authors suggests that SI and loneliness should be treated as a public health concern for older adults. SI and loneliness is an epidemic which has grown since the COVID-19 lockdown.

Critical Analysis of the literature

Exploration of the intersection of COVID-19, LTCRs and SI has stemmed from the upheaval of values systems surrounding the care of LTCRs. Due to significant media coverage, the general public has become aware of the state of LTCFs. This spotlight has also garnered research interest into the area of LTCRs, the pandemic and SI. Given the relatively recent emergence of COVID-19, relatively few studies on this topic were discovered. Additional limitations to the research are explored, including operationalization of terms, diversity of viewpoints, positionality, methodology, practical challenges and ethical constraints. The analysis of the literature concludes by arguing the importance of applying a critical social work lens to the topic of SI of LTCRs during COVID-19.

Operationalization

Research on SI and loneliness lacks consistent operationalization. As previously mentioned, these terms are often used interchangeably, but have differing meanings. The interrelatedness of these concepts has resulted in irregularities in both the measurement as well as definition of SI (Boamah et al., 2021). Within this major paper, some of the articles do not provide a definition of these terms, despite these terms being referred to on numerous occasions. This creates confusion for those in research and practice. Furthermore, the inconsistent operationalization of these terms poses challenges in applying meaningful comparisons (Boamah et al., 2021).

Diversity of Viewpoints

Missing from this topic are diverse viewpoints, such as from social workers, other professionals working within the LTC system and family members. Research fails to provide representation to some of these LTC stakeholders. This lack of diversity limits our understanding

of the topic through the paradigm of those who produce the research. For example, SI is often situated as a problem within an individual. This is common practice in a medical model which does not acknowledge structural factors contributing to SI, such as social determinants of health. Diverse viewpoints within the research of SI among LTCRs would provide alternative perspectives outside of medical model paradigms.

Positionality

The positionality of the researchers is an important consideration in the understanding of this topic. Reviewing the titles and roles of the research authors included in this major paper has revealed that they belong to the dominant hierarchy of society. Much of the literature on this topic was produced by researchers who have completed a PhD or who possess medical degrees. In multi-professional settings such as gerontology, medical perspectives often dominate (Ray et al., 2014). This provides a possible rationale for the overriding medical voice within the research. Not only are these individuals highly esteemed and valued in mainstream society, they are a product of a westernized educational system which reinforces dominant ways of research production through enlightenment "truth seeking" methods. These dominant viewpoints are partial, which is demonstrated by the narrow focus of SI as an individual concern. Individuals from alternative social positions may provide a greater depth of knowledge on the areas in which SI has impacted LTCRs during the pandemic.

Methodology

Research positionality not only limits the research topics, but also impacts the diversity of methodologies chosen to investigate this topic. Much of the research is limited to literature reviews, commentaries and few scoping reviews, utilizing an etic approach where the researcher takes an objective perspective to gather information and refrains from influencing the research

(Reid et al., 2017). This is in contrast to emic approaches which use inside perspectives to gather knowledge, and are branded as subjective forms of inquiry driven by researcher values (Reid et al., 2017). Only three studies were identified which diverged from these methodologies. The first was a study by Ayalon et al. (2020a). The authors used in-depth qualitative interviews of long-term residents in order to explore the experiences of LTCRs during the lockdown orders. A second study by Harden et al. (2020) approached the research through the examination of a case study of a 91-year-old LTCR. The authors examined the reoccurring themes of this case study. Finally, a report done by the Office of the Seniors Advocate of BC (2021) included a survey of LTC and assisted living staff within BC. They asked staff to reflect on how COVID-19 preventative measures impacted LTCRs' well-being. The lack of diverse methodology limits our understanding of SI of LTCRs during the COVID-19 pandemic. Research findings were interpreted through the lens of the researcher, which bolsters understanding of the topic through the researchers own paradigm rather than through representational strategies (such as quotes) which present and contextualize participant experiences (Reid et al., 2017). This lack of diversity in methodology and analysis may also be influenced by certain ethical and practical limitations affecting this topic.

Practical Challenges

Research within LTCFs during the pandemic can cause some practical challenges. The first practical consideration is the newness of the impacts of the COVID-19 pandemic on LTCR experiences of SI and the limited amount of research. One of the challenges of this literature review was in locating research articles on this topic, as many articles found included letters to the editor and commentaries. These articles signal a need for further research in this area. A second practical consideration is a researcher's ability to carry out different methodologies

during the COVID-19 pandemic where limited in-person contact with individuals is encouraged. This can also prevent the use of certain methodologies, such as field observations, as well as hinder the acquisition of research participants. A final consideration which may limit the types of methodologies chosen may be time-constraints. For instance, many LTC facilities are experiencing staffing shortages. This may result in staff spending more of their time caring for residents in LTC facilities, constraining their free time to participate in other tasks, such as assisting researchers in facilitating interviews with residents. This is a possible reason that the focus of the literature relies on the interpretations of doctors and researchers both within the field and in academia.

Ethical Constraints

In addition to the practical constraints, there are ethical considerations to research within LTCFs which may have caused barriers to the use of alternate methodologies. The first ethical consideration relates to confidentiality. Institutional settings pose challenges for confidentiality due to the amount of surveillance and lack of private spaces within LTCFs. This can impact one's willingness to participate in a research project and provide honest feedback when the information shared may be unfavorable towards LTC operations, staff or residents. A second ethical consideration in research of LTC is consent. This can be especially challenging if one's research participants are residents within LTC facilities who may experience limited capacity. Arguably, it is easier to obtain consent from individuals such as medical doctors than other vulnerable populations. These ethical considerations may have been barriers to the use of alternative methodologies.

Social Work Lens

What is largely missing from this research is a social work lens. Social workers deliver a unique voice in social justice which is not often replicated by other professionals. To clarify ambiguity surrounding the term social justice, the author offers the following definition to ground the reader's understanding of this term:

> Social justice means people from all identity groups have the same rights, opportunities, access to resources and benefits. It acknowledges that historical inequalities exist and must be addressed and remedied through specific measures including advocacy to confront discrimination, oppression, and institutional inequalities, with a recognition that this process should be participatory, collaborative, inclusive of difference, and affirming of personal agency. (Ash, 2020, para 7)

As a practicing social worker, one of the main concerns I have with this research is that the issue of SI and loneliness, and the proposed solutions, are situated at the individual level. This narrow view of SI disregards the ways in which our structures and agist beliefs reinforce SI. SI in not solely a concern of residents of LTC facilities, but permeates all ages and living situations. Humans evolved from living in groups of 20-30 people, all contributing towards the survival of the group. Thus, humans found meaning in group membership and relationships of mutuality, which is mirrored in RCT. The structural environments of LTCFs limits older adults' ability to maintain social connections with individuals outside of the facility and also limit LTCRs' ability to contribute, and have purpose, within LTCFs. Mutual relationships become one-sided, as LTCRs rely on staff to support their health and emotional needs. Day et al. (2020) suggested that LTCFs co-exist in the same location as preschool centres. This is just one possible integration between LTCFs and other centres which can co-create meaningful and mutual relationships

between LTCRs and others. These possible solutions also involve intergenerational mixing which can assist both younger and older generations in perspective taking, helping to counter ageist views. Tackling SI in a meaningful and enduring way must involve interventions at the macro level, involving multiple stakeholders and influencing politics.

Conclusion

Since the COVID-19 pandemic, SI has been exacerbated among LTCRs and has been termed a secondary pandemic. Residents of LTCFs are at heightened risk of experiencing SI due to LTCRs' communication barriers, LTCRs' cognitive impairment, lack of integration between the LTCF and broader community, social determinants of health and "oldering" (Boamah et al., 2021; Barbosa-Neves, 2019). Restrictive public health orders, such as the restriction of visitors, limited activities and interactions, and constrained movement of staff and volunteers have amplified SI within LTCF (Chu et al., 2021; Office of the Seniors Advocate of BC, 2021). RCT posits that disconnection results in numerous negative health outcomes (Jordan, 2018), which include negative mental health such as depression and anxiety in addition to increased risk of premature mortality (Bethell, 2021; Day et al., 2020). Family caregivers have voiced their concerns regarding these public health measures and have been mischaracterized as visitors to LTCFs (Tupper et al., 2020), rather than being acknowledged for the integral roles they serve in ensuring LTCRs receive the care that they need to lead fulfilling lives (Hado & Feinberg, 2020; Tupper et al., 2020).

Literature has revealed the role that ageism has played in the treatment of LTCRs within LTCFs during the COVID-19 pandemic. Older adults have been treated as a homogenous group, devalued by aging bodies and minds (Bravo-Segal & Villar, 2020; Ivan et al., 2020). Ageism has framed public health policy and design, through protracted lockdown measures for older adults

and utilizing age as a criterion for who receives resource-scarce medical equipment and supplies (Fraser et al., 2020; Bravo-Segal & Villar, 2020). These ageist practices demonstrate the AOP notion of the biomedicalization of aging, where individuals "are reduced to aging bodies and minds in need of surveillance and treatment from a medical-industrial complex" (Baines, 2017, p. 194).

This raises ethical debate surrounding the treatment of LTCRs, including autonomy, surveillance, individual versus collective rights, in addition to bioethical concerns of harm and proportionality, reciprocity, transparency by government, the media and LTCFs, beneficence and non-maleficence and finally justice (Lively, 2021; Swiffen, 2020). In addition to ethical arguments surrounding public health measures, Cohen (2020) found that SI leads to greater susceptibility to infection and disease if exposed to COVID-19, as individuals with higher stress levels become more vulnerable to upper respiratory infection.

To ameliorate the effects of SI within LTCFs, interventions were proposed at the micro, mezzo and macro level. At the micro level, improved communication between LTCFs and family members, use of technology to maintain connection through the funding of devices by provincial medical services plans, LTCF staff support in supporting safe social interactions and the increased monitoring and assessment of SI of LTCRs were proposed. At the mezzo level, interventions included the group interventions which address a targeted health need while promoting social connection as well as intergenerational mixing and letter writing campaigns. Finally, macro interventions sought to tackle the structural components of SI by coalition building to bring increased awareness, address research gaps and developing targeted and multi-faceted interventions which address underlying causes, such as ageism.

The research surrounding SI among LTCRs during the COVID-19 pandemic is a newly emerging area, with many opportunities for research. As most of the research is framed from a medical paradigm, there are opportunities for diverse perspectives such as social workers, to ensure that SI is not solely framed as an individual concern but from a broader perspective which includes the structural elements of ageism. In a micro practice, social workers should implement regular monitoring and assessment for SI of LTCRs. At the mezzo level, social workers should take on the role of advocacy against paternalistic policies which impact on LTCRs' autonomy in addition to supporting safe social interactions for LTCRs. Most importantly, social workers should address ageism and the structural system of LTC which precipitates SI through their involvement in coalition building and developing political awareness.

This research has provided a framework of understanding of SI among LTCRs during the pandemic, with room for further exploration. Further questions which could be explored within the context of LTCFs, is whether society is able to allow older adults to live at risk and whether consent should be requested prior to some of the restrictive public health measures placed upon LTCRs. With an aging population, more research is warranted to ensure that we maintain a healthy quality of life for older adults.

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