What are the holistic care impacts among individuals living through the COVID-19 pandemic in residential or community care settings? An integrative systematic review.

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REVIEW ARTICLE

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What are the holistic care impacts among individuals living through the COVID-19 pandemic in residential or community care settings? An integrative systematic review

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Abstract

Introduction: To critically synthesise evidence in relation to the holistic care impacts (physical, psychological, social, spiritual, and environmental well-being) among individuals living in residential aged care facilities (RACFs) with restrictions during the COVID-19 pandemic.

Methods: An integrative systematic review followed a pre-registered protocol and has been reported according to the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) Guidelines. Electronic databases were searched from inception to June 2022. Qualitative, quantitative, and mixed methods studies were included. All articles were double screened according to a pre-determined eligibility criterion. The review process was managed using Covidence systematic review software. Data from the studies were extracted, methodological quality appraisal conducted, and a narrative synthesis conducted.

Results: 18 studies were included. The impact of restrictive practices and periods of lockdown impacted older people on all levels of individual quality-of-life. With or without COVID-19, residents experienced functional decline and many experienced malnutrition, increased incontinence, increased pain, and poorer general health and significant psychological distress. Depression increased with reduced social contact, as did anxiety and loneliness. Some residents spoke of suicidal ideation.

Conclusion: It is highly plausible that further outbreaks may prompt knee-jerk reactions from public health departments and governing bodies to continue to restrict and lockdown facilities. Public health COVID-19 outbreak policy for aged care across the globe will need to consider the benefits verses risk debate given the findings uncovered in this review. These findings showed that it is vital that policy considers quality-of-life domains not solely survival rates.

KEYWORDS
aged care, COVID-19, holistic health, older people, systematic review

1 | INTRODUCTION

Globally, the coronavirus disease 19 (COVID-19) pandemic has affected over 786,187,096 people and caused over 6 million deaths (Zhu et al., 2020). It is widely accepted that the ageing population are the most vulnerable and susceptible to the COVID-19 virus with risk of severe disease, hospitalisation, and death (Holt et al., 2020). The World Health Organisation (WHO, 2020) has estimated that up to half of COVID-19 related deaths in Europe were residents living in RACFs. Evidence has identified that hospitalisations due to COVID-19 increased by age from 1.04% in 20–29 years old, to 18.4% in those greater than 80 years (Verity et al., 2020).

Effective isolation is especially difficult for people living in RACFs and assisted living communities due to necessarily close interactions with personal care workers, allied health practitioners, and nurses (Crotty et al., 2020). Most RACFs have placed a ban on visitors, cancelled group activities, ceased communal dining, and enforced strict social distancing rules, resulting in a profound negative impact on holistic person-centred care (Simard & Volicer, 2020). As the pandemic plays out across the world research and data are continually emerging, State and Commonwealth Governments and healthcare policymakers require current evidence to inform future practice to protect residents in RACFs to mitigate the impacts of COVID-19 but optimise recovery. To the best of our knowledge, no one has yet critically synthesised the evidence to understand the holistic person-centred impacts of the pandemic on our ageing population in RACFs. Holistic care is defined as complete or total patient care that considers the social, physical, psychological, cognitive, spiritual, and environmental well-being of the person, his or her response to illness and the effect of the illness on the ability to meet self-care needs (Ventegodt et al., 2016). Holistic person-centred care considerations should be at the forefront of policy makers rather than focusing on the physical consequences of COVID-19 alone (Kelley-Gillespie, 2009). Currently, researchers, clinicians, gerontological nurses, and policymakers are poorly informed about the holistic care impacts of COVID-19 among the ageing population living in RACFs in the existing evidence (Hashan et al., 2021) this systematic review aimed to address this gap. This systematic review addressed the following research question:

What are the holistic person-centred impacts among individuals living in RACFs during the COVID–19 pandemic?

What does this research add to existing knowledge in gerontology?

- This review identified the holistic care needs of people living in residential aged care facilities in a range of countries during the COVID-19 pandemic.

What are the implications of this new knowledge for nursing care with older people?

- It is highly plausible that further outbreaks and stronger variants will prompt knee-jerk reactions from public health departments and governing bodies to continue to restrict and lockdown facilities. Public health COVID-19 outbreak policy for aged care across the globe will need to consider the benefit verses risk debate given the findings of this review.

How could the findings be used to influence policy or practice or research or education?

- These findings show it is vital that policy considers quality-of-life domains not solely survival rates. Being able to remain active, physically, mentally, social, and spiritually in a safe environment is paramount.

2 | METHODS

2.1 | Design

An integrative systematic review was conducted and reported according to Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page, McKenzie, et al., 2021). This review followed a protocol registered in PROSPERO [CRD42022318879]. An integrative systematic review was considered appropriate to provide a comprehensive understanding of all previous qualitative, quantitative, and mixed methods studies to understand the holistic health impacts among individuals living in RACFs.

2.2 | Definition of terms

Holistic (care): Complete or total patient care that considers the social, physical, psychological, cognitive, spiritual, and environmental well-being of the person, his or her response to illness, and the effect of the illness on the ability to meet self-care needs (Ventegodt et al., 2016).

Residential care: Residential aged care is for older adults who can no longer live in their own home. It includes accommodation and personal care 24 h a day care, as well as access to nursing and general health care services.

Community Care: Support older people with complex needs to help them stay at home. Approved aged care service providers work with care recipients to plan, organise, and deliver Home Care Packages.

Pandemic: COVID-19 pandemic. The World Health Organisation (WHO) on March 11, 2020, declared the novel coronavirus (COVID-19) outbreak a global pandemic (World Health Organisation, 2020).

2.3 | Search strategy

The APA PsycINFO, CINAHL, MEDLINE, Scopus, and Web of Science databases were searched from inception until June 2022 for

all relevant studies. See Table S1 for full record of database searches. Relevant systematic reviews were scrutinised for potentially relevant studies for screening. Reference lists of included studies were searched to identify further relevant studies. All studies were imported to the Covidence software for de-duplication and the screening process.

2.4 | Screening process

Following de-duplication in Covidence, two review authors independently screened the titles, abstracts and full text articles according to a pre-determined eligibility criterion. Any conflicts were resolved by discussion. Reasons for excluding full-text articles was documented in the PRISMA flow diagram.

2.5 | Eligibility criteria

2.5.1 | Study types

- Studies investigating holistic care impacts of the COVID-19 pandemic on residents of residential care homes or community care settings.
- Qualitative, quantitative, and mixed-method studies were included irrespective of research design.
- Studies published in English.

All commentaries, editorials, conference abstracts, and studies published in languages other than English were excluded.

2.5.2 | Participant types

- Older adults living in residential care or receiving community-based care services (including terms of nursing homes, long-term care facilities, retirement homes, and community care villages) were included.

2.6 | Quality assessment

Methodological quality evaluation was conducted on the primary studies using the Mixed Methods Appraisal Tool (MMAT) to enable a plethora of methodologies to be evaluated given the integrative systematic review design. The MMAT consists of seven questions which can be classified as 'yes', 'no', or 'unclear' (Hong et al., 2018). This assessment tool enables critical appraisal of all qualitative, quantitative, and mixed methods studies. Each domain of assessment is rated against, "no", "yes", and "unclear". Methodological quality assessment was performed by one reviewer and quality checked by a second reviewer.

2.7 | Data extraction

Data was extracted from all full text studies meeting the inclusion criteria. Data was extracted by one reviewer, and independently quality checked by a second reviewer. Data extraction tables were developed and tested on a small sample of studies and further refined through reviewer discussion until agreement reached on final formatting. The first table of data extraction included study characteristics, namely, purpose, setting, country, sample size, participant characteristics, sampling used, response rate, attrition, design, time points, and data collection tools. Two separate data extraction tables were used given the integrative systematic review design which extracted separately all quantitative outcome data (Table S2), and a separate table for all qualitative findings (Table S3). The separate extraction tables were used for all qualitative and quantitative findings in keeping with the integrative review methods (Whittemore & Knafl, 2005). For the qualitative studies, the findings were extracted to capture the themes reported in each study and a qualitative illustration was extracted to justify the generation of each individual finding. All qualitative findings and supporting illustrations were assessed for congruence and were given a ConQual ranking of either 'unequivocal' (clear association between the finding and illustration), 'equivocal' (unclear association between the finding and illustration, leaving it open to challenge), or 'not supported' (findings not supported by data) (Munn et al., 2014). Unsupported findings were not included in the final synthesis. For all quantitative findings, outcome data was extracted according to the definition of holistic care.

2.8 | Evidence synthesis

Primary research studies were tabulated, and narrative synthesis used to generate findings. The data synthesis process followed the integrated review methodology and involved data reduction (subgroup classification by study design), data comparison, (identifying patterns and themes through counting, clustering with comparisons and contrasts), and conclusion-drawing and verification (checking with the primary source data for accuracy) (Whittemore & Knafl, 2005).

3 | RESULTS

Database searches yielded 4520 studies, 1573 duplicates were removed before screening (see Figure 1). The full text of all 33 remaining potentially eligible studies were retrieved, and 15 papers were excluded with reasons, leaving 18 studies included. The studies were published in a range of countries including: Spain (3) (Cortés Zamora et al., 2022; Pereiro et al., 2021; Pérez-Rodríguez et al., 2021), Turkey (2) (Arpacıoğlu et al., 2021; Savci et al., 2021), United Kingdom (1) (Davies-Abbott et al., 2021), New Zealand (1) (Cheung et al., 2021), Israel (1) (Ayalon & Avidor, 2021), France

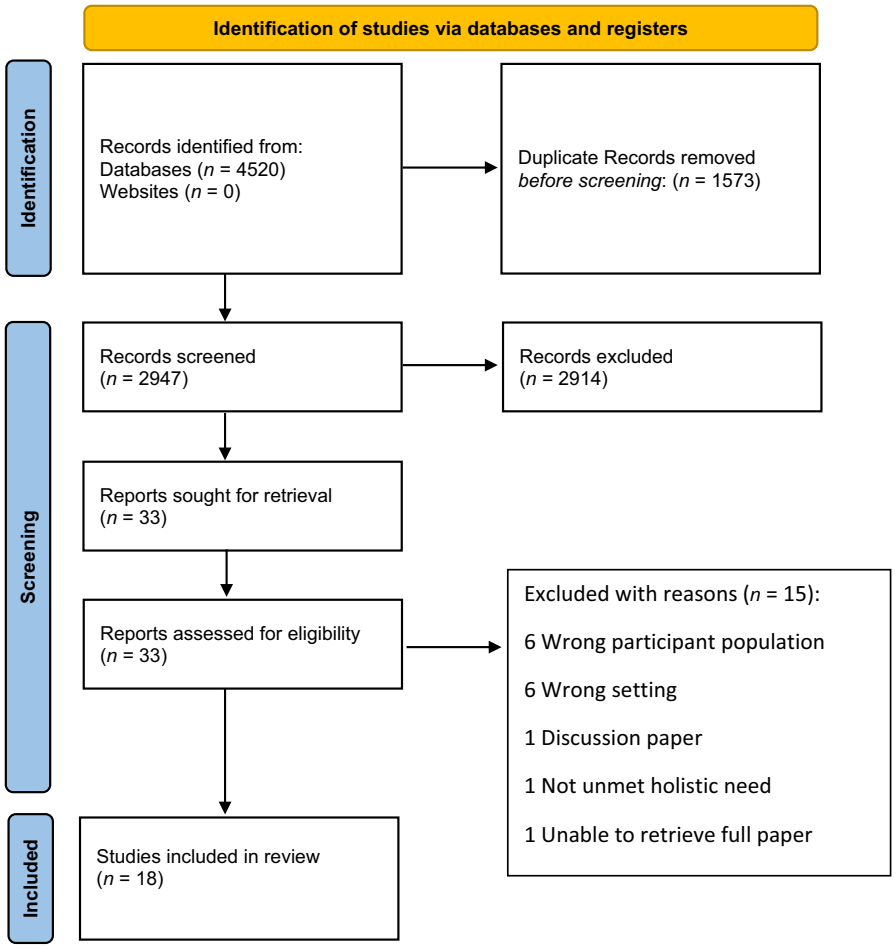

FIGURE 1 PRSIMA diagram. From: Page, McKenzie, et al. (2021).

(1) (El Haj et al., 2020), China (1) (Ho et al., 2022), Switzerland (1) (Huber & Seifert, 2022), Canada (1) (Ickert et al., 2021), Belgium (1) (Kaelen et al., 2021), United States of America (1) (Levere et al., 2021), Sweden (1) (Lood et al., 2021), Ireland (1) (Murphy et al., 2022), Croatia (1) (Solić et al., 2021), and Thailand (1) (Srifuengfung et al., 2021). All studies were conducted during the COVID-19 pandemic from early 2020 to mid-2021.

Eleven studies used a quantitative design and included: three cross-sectional, two correlational, three comparative, and three longitudinal designs. Across the quantitative studies the sample sizes varied from 58 to 14,510. Quantitative data was collected from a total of 15,755 aged care residents, 62% female, 38% male, aged 60–102 years old. Seven studies used qualitative methodology exploring the lived experiences of residents living through the COVID-19 pandemic. Sample sizes ranged from a single case-study design to 24 residents. All used thematic analysis of structured or unstructured interviews to capture qualitative findings. There were 130 residential care residents, ranging from 70 to 100 years old (see Table 1). The results of the methodological quality assessment are presented in Table 2.

3.1 | Holistic care impacts

Across the included studies, impacts reported included: psychological (16/18), physical (10/18), social (10/18), environmental (8/16), cognitive (7/18), and spiritual (7/18) (see Table 3).

3.1.1 | Psychological impacts

Sixteen studies reported on psychological well-being impacts experienced by nursing home and community care residents due to restrictions enforced during the COVID-19 pandemic (see Table 3). Aged care residents reported an increase in moderate depressive symptoms during the COVID-19 lockdown period of 2020 (Ayalon & Avidor, 2021) and 57.7% of residents reported being at risk of clinically significant depressive symptoms (Cortés Zamora et al., 2022). Several studies found statistically significant increases in the prevalence of anxiety and depression compared to pre-pandemic scores (Cortés Zamora et al., 2022; El Haj et al., 2020; Levere et al., 2021; Pereiro et al., 2021; Pérez-Rodríguez et al., 2021).

Qualitative findings from various countries revealed that the pandemic evoked feelings of depression, fear, anxiety, and loneliness. Residents reported feelings of sadness and frustration, many stated they were depressed (Ayalon & Avidor, 2021; Davies-Abbott et al., 2021; Ickert et al., 2021; Kaelen et al., 2021).

> I'm lonely here and sad, and as time goes on, its becoming, like there's a lot more people that's depressed, and I cry at night.
>
> (Ickert et al., 2021, page 1550)

The experience of lockdown, isolation, and restriction was particularly traumatising for some residents, who likened the feelings they

TABLE 1 Characteristics of included studies.

Author (year), Country	Purpose	Setting	Sample size	Participants	Sampling	Response rate	Attrition	Design	Time points	Data collection tools
Arpacıoğlu et al. (2021) Turkey	To investigate the levels of depression, anxiety, death anxiety and life satisfaction during the pandemic among nursing home (NH) residents and compare these variables with community-dwelling (CD) older adults	Nursing home & Community dwelling	NH residents (*N* = 66) CD (*N* = 67) (*N* = 133)	66.9% aged 65–79 years old 33.1% aged 80 years and older 58.6% female 41.4% male	Convenience	83.7% NH residents 60.9% CD older adults	n/a	Descriptive and cross-sectional design	1	*Questionnaires*: Sociodemographic data questionnaire: Unspecified questionnaire. Death Anxiety: Turkish death anxiety scale (TDAS). Life Satisfaction: Satisfaction with life scale (SLS). Depression, anxiety and stress: Depression, anxiety and stress scale-21 (DASS-21)
Ayalon and Avidor (2021) Israel	To explore the personal experiences of older adults living in continuing care retirement communities (CCRC) whilst in a lockdown due to the COVID-19 pandemic	Continuing care retirement communities (CCRC)	*N* = 24	Age range 75–95 years Mean age 83.75 years 87.5% female 12.5% male	Convenience	Not reported	n/a	Qualitative	1	*Interviews*: Via telephone *Thematic Analysis* of interview transcripts using constant comparisons and contrasts
Cheung et al. (2021) New Zealand	To investigate the impact of New Zealand's (NZ) first wave of COVID-19, which included a nationwide lockdown, on the health and psycho-social well-being of Maori, Pacific Peoples and NZ Europeans in aged residential care (ARC)	Aged Residential Care (ARC)	2019 (*N* = 13,164) 2020 (*N* = 12,136)	Age range 60–90 + years **2019 (*N* = 13,164)** 60.3% female 39.7% male **2020 (*N* = 12,136)** 58.7% female 41.3% male	Consecutive	n/a	92.1%	Comparative	2 (Pre & Intra COVID-19)	interRAI Long-term Care Facilities (interRAI LTCF) geriatric assessment
Cortes Zamora et al. (2021) Spain	To analyse the psychological and functional sequelae of the COVID-19 pandemic among older adults living in long term care facilities	Long-term care facilities (LTCF)	*N* = 215	Age range >65 years Mean age 83 years 62.8% female 37.2% male COVID-19 +ve 65.1% (*N* = 140)	Convenience	Not reported	22.6%	Cohort longitudinal study	2	Basic activities of daily living (BADL): Barthel index score; Frailty status: the FRAIL instrument; Ambulation: Functional Ambulation Classification (FAC); Medical records; Comorbidity: the Charlson Comorbidity Index; Nutritional Status: Mini Nutritional Assessment Short Form (MNA-SF); Cognitive and affective status: Short Portable Mental Status Questionnaire Pfeiffer (SPMSQ) & the 5 -item Geriatric Depression Scale (GDS-5). Psychological impact: Hospital Anxiety and Depression Score (HADS); Posttraumatic stress disorder (PTSD): 8-item Treatment-Outcome Post-Traumatic Stress (TOP-8) Scale; Chronic sleep disturbances and insomnia: Insomnia in the Elderly Scale (IES) tool

(Continues)

TABLE 1 (Continued)

Author (year), Country	Purpose	Setting	Sample size	Participants	Sampling	Response rate	Attrition	Design	Time points	Data collection tools
Davies-Abbott et al. (2021) UK	To understand the lived experience of a person living with dementia in a care home during the COVID-19 pandemic	Residential care home for people with dementia	*N* = 1	Female 71 years old	Purposive	Not reported	n/a	Single-case study	1	Thematic analysis of semi-structured interviews
El Haj et al. (2020) France	To investigate the effects of restrictive measures against COVID-19, have on the mental health of people with Alzheimer's Disease who live in retirement homes	Retirement home	*N* = 58	Mean age 71.79 years 63.8% female (*N* = 37) 36.2% male (*N* = 21)	Convenience	72.5%	n/a	Comparative	1	Anxiety and Depression: Hospital Anxiety and Depression Scale (HADS)
Ho et al. (2021) China	To explore the lived experiences of loneliness of older adults in residential care homes during a 5-month period of the COVID-19 pandemic	Residential Care Homes (RCH)	*N* = 15	Age range 70–97 years Mean age 83.4 years 80% female 20% male	Convenience	83.3%	n/a	Qualitative	1	Thematic analysis of un-structured interviews
Huber and Seifert (2022) Switzerland	To investigate the subjective loneliness among older adults living in long-term care facilities (LTCF) during the COVID-19 pandemic and to determine the association between loneliness experienced and various independent variables to gain a better understanding of the indicators of loneliness during the pandemic	Long-term Care Facilities (LTCF)	*N* = 828	Mean age 87.78 years 75% female 25% male	Convenience	54.3%	n/a	Descriptive and correlation study	1	*Questionnaire*: Unspecified. Additional six item Loneliness Short Scale (LSS)
Ickert et al. (2021) Canada	To examine the experiences and perspectives of residents [and family members] living in long-term care (LTC) and supportive care (SC) centres	Long-term care (LTC) and supportive living (SL)	*N* = 14	Mean age 68.1 years 50% female 50% male	Purposive and convenience	73.7	n/a	Qualitative	1	Thematic analysis of un-structured interviews
Kaelen et al. (2021) Belgium	To better understand the psychosocial and mental health needs of nursing home (NH) residents during times of COVID-19.	Nursing homes (NH)	*N* = 56	Age range 58–101 years Mean age 85 years 62.5% female 37.5% male	Purposive and convenience	87.5%	n/a	Qualitative	1	Thematic analysis of structured interviews

TABLE 1 (Continued)

Author (year), Country	Purpose	Setting	Sample size	Participants	Sampling	Response rate	Attrition	Design	Time points	Data collection tools
Levere et al. (2021) USA	To quantify the effects on the COVID-19 pandemic on nursing home (NH) resident well-being	Nursing homes (NH)	*N* = 14,510	Mean age 80.4 years 67.2% female 32.8% male	Consecutive	n/a	64% in 2020 data	Cohort longitudinal study	Each week from March – July 2020	Long-Term Care Minimum Data Set (MDS); Depressive symptoms: Patient Health Questionnaire-9 (PHQ-9); Cognition: The Cognitive Functioning Scale; Physical function: The Activities of Daily Living score; Comparable data: obtained March 2017, 2018, 2019
Lood et al. (2021) Sweden	To understand and report on the impact of the COVID-19 pandemic restrictions on the everyday lives of frail older persons living in nursing homes.	A Nursing Home (NH)	*N* = 10	Age range 85–100 years Mean age 93.8 years	Convenience	Not reported	n/a	Qualitative	1	Thematic analysis of structured interviews
Murphy et al. (2022) Ireland	Study aims to describe the experiences of residents relocating between long-term care facilities (LTC) at the onset of the COVID-19 pandemic.	Long-term care facilities (LTC)	*N* = 10	Age range 72–97 years Mean age 84 years 50% female 50% male	Purposive	Not reported	n/a	Qualitative	1	Thematic analysis of semi-structured interviews Demographic data obtained through medical records
Pereiro et al. (2021) Spain	To measure the decline in cognitive, functional, and affective status in a care facility after the lockdown in the first wave of the COVID-19 pandemic and to compare it with the previous measures to determine if this decline was accelerated.	Long-Term Care Facilities (LTCF)	*N* = 98	Aged range 60–102 years Mean age 83.41 years 62% female 38% male	Convenience	95.1%	100%	Cohort longitudinal study	4 (3 retrospective pre-COVID & 1 post first-wave)	Cognitive Status: Mental Mental State Exam (MMSE) & Spanish version of the Clinical Dementia Rating (CDR); Depressive symptomatology: Spanish Version 15-item Geriatric Depression Scale (GDS); Functional Status: Spanish Version of the Barthel Index (BI); Sociodemographic data
Pérez-Rodríguez et al. (2021) Spain	To compare functional, cognitive, and nutritional status before and after COVID-19 pandemic among institutionalised older adults	Nursing homes (NH)	*N* = 435	Mean age 86.7 years 78.4% female 21.6% male 43.9% COVID +ve	Convenience	n/a	n/a	Comparative	2	Demographic data; Functional Status: Barthel Index & the Functional Ambulation Categories (FAC) scale; Cognitive status: Global Deterioration Scale (GDS), Lobo's Mini-Examen Cognoscitivo (MEC) and the 10-item mental status questionnaire (Pfeiffers SPMSQ); Nutritional status: Mini Nutritional Assessment-Short Form (MNA-SF)

(Continues)

TABLE 1 (Continued)

Author (year), Country	Purpose	Setting	Sample size	Participants	Sampling	Response rate	Attrition	Design	Time points	Data collection tools
Savci et al. (2021) Turkey	To evaluate the fear of COVID-19, loneliness, resilience, and quality of life levels in older adults in a nursing home during the pandemic, and the effect of these variables and descriptive characteristics on their quality of life	A nursing home	N = 103	Age range 65–94 years Mean age 73.3 years 20.4% female 79.6% male All residents live in shared rooms of 3–5 beds	Convenience	Not reported	n/a	Descriptive and correlation study	1	Participant information form Mini Mental State Exam (MMSE) Fear: The brief Resilience Scale, the fear of COVID-19 Scale (FCV-19S). Loneliness: The loneliness Scale for the Elderly (LSE); Quality of life: The World Health Organisation Quality of Life-BREF Turkish Version (WHOQOL-BREF-TR)
Solić et al. (2021) Croatia	To examine the links between social isolation, loneliness, and perception of social support during social isolation due to COVID-19	Homes for the elderly and infirm	N = 98	Age range 61–95 years Mean age 81.86 years 73.5% female 26.5% male	Convenience	61.25%	n/a	Cross-sectional study	1	Social Provision Scale (SPS), the short-form UCLA Loneliness Scale; the Multidimensional Scale of Perceived Social Support (MSPSP)
Srifuengfung et al. (2021) Thailand	To investigate how COVID-19 has affected the life and psychological status of older adults living at long-term care centres	Long-term care (LTC) centres	N = 200	Mean age 76.4 years 66.5% female 33.5% male	Convenience	97.5%	n/a	Cross-sectional study	1	Socio-demographic data; Post-traumatic Stress: The 17-item Post-traumatic Stress Disorder Checklist (PCL-17); Depression: The 9-item Patient Health Questionnaire (PHQ-9); Anxiety: 7-item Generalised Anxiety Disorder Scale (GAD-7); Semi-structured interviews

felt to those of when they experienced the Holocaust or World War II, but they still had their freedom (Ayalon & Avidor, 2021; Kaelen et al., 2021). Others expressed feelings of being claustrophobic, abandoned and described the lockdown periods as the most horrible period of their lives (Ayalon & Avidor, 2021; Davies-Abbott et al., 2021; Kaelen et al., 2021). The pandemic created a disconnection from their families, and many felt vulnerable, lonely, and expressed that they lacked significance to others (Ho et al., 2022; Murphy et al., 2022).

> I am still lonely. My daughter and I are in two parallel worlds. I am not a significant one for others. I am not afraid of getting the disease [COVID-19]. I hope I get it, then everything is ended.
>
> (Ho et al., 2022, page 284)

Older adults expressed greater fear of further lockdowns rather than the fear of contracting COVID-19, and some suggested suicide was an option if the lockdowns continued (Kaelen et al., 2021).

> We don't have a life anymore since COVID-19. Yes, I think more and more about … suicide because I think I'm at the end of a depression if it continues. Before I go to sleep, I wish I wouldn't wake up the next day
>
> (Kaelen et al., 2021, page 10)

Many spoke of losing friends and family members and not being able to leave to attend funerals or visit graves of loved ones (Ayalon & Avidor, 2021; Ickert et al., 2021; Kaelen et al., 2021; Murphy et al., 2022). Residents felt infantilised when they were not asked about their opinions and felt they were losing their autonomy and as the lockdown measures continued, many felt angry and stressed (Davies-Abbott et al., 2021; Kaelen et al., 2021; Murphy et al., 2022).

3.1.2 | Physical impacts

Ten studies reported on physical impacts experienced by nursing home and community care residents due to restrictions enforced during the pandemic (see Table 3). Residents experienced substantial weight loss (Cortés Zamora et al., 2022; Levere et al., 2021) and malnutrition (Pérez-Rodríguez et al., 2021). Residents were found to be at higher risk of a decline in ambulation, higher frailty levels compared to before the pandemic (Cortés Zamora et al., 2022; Huber & Seifert, 2022; Pérez-Rodríguez et al., 2021). Furthermore, evidence identified an increase in episodes of incontinence during the pandemic period compared with similar periods in previous years pre-COVID-19 (Levere et al., 2021; Savci et al., 2021; Srifuengfung et al., 2021). Contrastingly, two studies reported that the general pattern of age-related functional decline was not significantly altered by the strict COVID-19 lockdown periods (Cheung et al., 2021; Pereiro et al., 2021).

Residents articulated concerns about their physical health due to public health restrictions. Residents were no longer able to

TABLE 2 Mixed methods assessment tool.

Qualitative study	Item number of check list						
	S1.	S2.	1.1.	1.2.	1.3.	1.4.	1.5.
Ayalon and Avidor (2021)	Y	Y	Y	U	U	N	N
Davies-Abbott et al. (2021)	Y	Y	Y	Y	Y	Y	Y
Ho et al. (2021)	N	U	U	U	U	Y	Y
Ickert et al. (2021)	Y	Y	Y	Y	Y	Y	Y
Kaelen et al. (2021)	Y	Y	Y	Y	Y	Y	Y
Lood et al. (2021)	Y	Y	Y	Y	U	U	U
Murphy et al. (2022)	Y	Y	Y	Y	Y	Y	Y

Item number check list key[a]: S1. Are there clear research questions, S2. Do the collected data allow to address the research questions, 1.1. Is the qualitative approach appropriate to answer the research question, 1.2. Are the qualitative data collection methods adequate to address the research question, 1.3. Are the findings adequately derived from the data, 1.4. Is the interpretation of results sufficiently substantiated by data, 1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation

Quantitative descriptive studies	Item number of check list						
	S1.	S2.	4.1.	4.2.	4.3.	4.4.	4.5.
Arpacıoğlu et al. (2021)	Y	Y	N	N	Y	U	Y
Cheung et al. (2021)	Y	Y	Y	Y	Y	Y	Y
Cortes Zamora et al. (2021)	Y	Y	Y	Y	Y	Y	Y
El Haj et al. (2020)	Y	Y	N	N	N	N	Y
Huber and Seifert (2021)	U	U	Y	Y	U	N	U
Levere et al. (2021)	Y	Y	Y	Y	Y	Y	Y
Pereiro et al. (2021)	Y	Y	Y	Y	Y	Y	Y
Pérez-Rodríguez et al. (2021)	Y	Y	Y	Y	Y	Y	Y
Savci et al. (2021)	Y	Y	N	N	Y	U	Y
Srifuengfung et al. (2021)	Y	Y	Y	Y	Y	U	Y
Solić et al. (2021)	Y	Y	U	U	Y	U	U

S1. Are there clear research questions, S2. Do the collected data allow to address the research questions, 4.1. Is the sampling strategy relevant to address the research question, 4.2. Is the sample representative of the target population, 4.3. Are the measurements appropriate, 4.4. Is the risk of non-response bias low, 4.5. Is the statistical analysis appropriate to answer the research question

[a]Three levels of assessment quality scores: Yes (Y) Unclear (U) No (N).

access physiotherapy sessions, and some took to exercising alone in their rooms, to try and halt any further physical decline (Ickert et al., 2021). Some residents stated they had missed physiotherapy sessions for over three months and had significant pain levels due to being inactive (Ho et al., 2022; Kaelen et al., 2021).

> I'm working on improving my own (physical well-being) by exercising alone in my room
>
> (Ickert et al., 2021, page 1550)

3.1.3 | Social impacts

It was common for residents to experience loneliness during the pandemic (Huber & Seifert, 2022) with moderate to severe negative impact on familial relationships (Arpacıoğlu et al., 2021; Savci et al., 2021; Srifuengfung et al., 2021). Many individuals started using modern forms of communication (such as FaceTime, Zoom, etc) to stay in social contact with others (Solić et al., 2021). Qualitative studies revealed that during periods of lockdown, the lack of close physical contact was viewed as the most damaging aspect of their quality of life (Davies-Abbott et al., 2021). Strict lockdowns meant residents were unable to physically interact with other residents, staff, support services and family members (Kaelen et al., 2021; Lood et al., 2021).

> More than my health, I really feel that it is my freedom that I have been robbed of and I find it difficult to bear. It's horrible to be locked up, it's like being in a prison.
>
> (Kaelen et al., 2021, page 6)

Patio visits were implemented at times, but residents missed the physical closeness of hugging their loved ones. Some residents expressed how being hugged embodied the feeling of being cared about and were grateful to the nurses who hugged them and made them feel loved (Ho et al., 2022; Huber & Seifert, 2022). Residents explained how the positive relationships with staff members made them feel safer and protected from the virus (Murphy et al., 2022).

TABLE 3 Frequency of quality-of-life domains.

Study	Social wellbeing	Physical wellbeing	Psychological wellbeing	Cognitive wellbeing	Spiritual wellbeing	Environmental wellbeing	Number of domains explored within each review
Arpacıoğlu et al. (2021)	✓	–	✓	–	–	–	2
Ayalon and Avidor (2021)	–	–	✓	–	–	✓	2
Cheung et al. (2021)	–	✓	✓	–	–	–	2
Cortes Zamora et al. (2021)	–	✓	✓	–	–	–	2
Davies-Abbott et al. (2021)	✓	–	✓	✓	✓	✓	5
El Haj et al. (2020)	–	–	✓	–	–	–	1
Ho et al. (2021)	✓	✓	✓	–	✓	–	4
Huber and Seifert (2021)	✓	–	–	–	–	–	1
Ickert et al. (2021)	✓	✓	✓	✓	–	✓	5
Kaelen et al. (2021)	✓	✓	✓	✓	–	✓	5
Levere et al. (2021)	–	✓	✓	✓	–	–	3
Lood et al. (2021)	–	–	–	–	–	✓	1
Murphy et al. (2022)	✓	–	✓	–	✓	✓	4
Pereiro et al. (2021)	–	✓	✓	✓	–	–	3
Pérez-Rodríguez et al. (2021)	–	✓	✓	✓	–	–	3
Savci et al. (2021)	✓	✓	✓	✓	-	✓	5
Solić et al. (2021)	✓		✓	–	–	–	2
Srifuengfung et al. (2021)	✓	✓	✓	–	–	✓	4
Number of domains explored across all reviews	10	10	16	7	3	8	–

> My home is here. The nurses are very good. They are concerned about my feeling of being trapped every day. They hug me. They talk with me. They encourage me to reach out within this home, of course, wearing a mask. I don't feel anxious here. I feel loved
>
> (Ho et al., 2022, page 285)

It was common for individuals to experience a loss of social connection during the pandemic, which greatly impacted their well-being (Davies-Abbott et al., 2021; Ho et al., 2022; Ickert et al., 2021; Kaelen et al., 2021; Murphy et al., 2022). Residents reported spending up to four months isolated alone in their rooms, friendship groups were dismantled as residents were unable to dine with others and many reported simply having nothing to do (Davies-Abbott et al., 2021; Ickert et al., 2021).

3.1.4 | Environmental impacts

Residents that were offered opportunities for connection within their living environment felt safe and had statistically significant higher mental wellbeing scores (Savci et al., 2021). Residents who shared a room also had higher mental and environmental scores than those residing in single rooms (Srifuengfung et al., 2021). Many expressed that the change in environment meant that their homes were likened to prisons, some were lucky enough to have a window with a view, but others were not. Some residents viewed the restrictive pandemic measures as 'tough, but for your own good', having to respect that this was just the way that things were now due to the virus (Ickert et al., 2021; Kaelen et al., 2021; Murphy et al., 2022). A single-case study in the UK highlighted how residents were forbidden to go outside and that they felt as if they had been deprived of living and the only way out of the facility was to die (Davies-Abbott et al., 2021). During the pandemic everyday choices were taken away, and residents articulated that they were no longer able to choose what to do, when to do it, and with whom (Ickert et al., 2021; Lood et al., 2021).

> We are social beings. One is not made to stay alone in one's room, it is enough to become crazy. We can read, we can watch television, but its not the same thing as living with others. The lack of contact, I didn't hold anybody since … I think the lack of physical contact is very hard. It's almost unhuman. It's not natural.
>
> (Kaelen et al., 2021, page 8)

3.1.5 | Cognitive impacts

Several studies identified significant changes in cognitive decline during strict periods of lockdowns, see Table 3 except for one study which found no changes in cognitive function over time (Pereiro et al., 2021). Residents affected by dementia had increased interfering, touching and fiddling behaviours which was especially challenging from an infection

control perspective (Davies-Abbott et al., 2021; Ickert et al., 2021). Residents expressed sadness for other residents with dementia because they were waiting, and waiting, for their families to visit, but they did not understand the bans on visitation (Ickert et al., 2021).

> For the rest of the residents (with dementia), they sat in their chairs and just looked lost, you can just see it, the mood of the people
>
> (Ickert et al., 2021, page 1550)

3.1.6 | Spiritual impacts

Only three qualitative studies (Davies-Abbott et al., 2021; Ho et al., 2022; Murphy et al., 2022) reported on spiritual well-being impacts. No quantitative studies reported on this domain. Findings revealed that due to restrictions church services were prohibited, and many residents were no longer able to attend their usual Sunday Religious Services (Davies-Abbott et al., 2021).

> Without church activities, I feel lonely because we cannot group together and cannot update each other. It's an environment that cannot be replaced by telephone calls. Luckily, I like reading the bible. When I read the bible, I pray. God listens to me, and I hear His voice. I am reassured.
>
> (Ho et al., 2022, page 285)

Residents expressed that this part of their life could not be replaced by a telephone call, and they needed to feel connected spiritually to God (Murphy et al., 2022). Some were still able to read the bible, and many prayed alone because they felt disconnected to their faith community (Ho et al., 2022).

4 | DISCUSSION

This systematic review set out to identify the holistic care needs of individuals living in RACFs. Quantitative studies focused mainly on the physical and psychological well-being domains whereas qualitative studies revealed that restrictive practices and periods of lockdowns negatively impacted all aspects of quality-of-life.

For many public healthcare orders globally, it is widely accepted that only the physical domain had been considered to date, and this review has added an important insighted into the impacts on holistic care. The driving force of restrictions and lockdowns across the world was to keep our vulnerable safe and to minimise the risk of them contracting COVID-19. However, this review has added an important new lens to the experiences of older people living in RACF globally. This review has revealed the detrimental effects of restricting interactions with family and fellow residents across all domains of quality of life. With or without COVID-19, residents experienced a functional decline and many experienced malnutrition, increased incontinence, increased pain, and poorer general health and significant psychological distress. Depression increased with reduced social contact, as did anxiety and loneliness, with many ageing residents considered suicide with no reports of support to cope.

Cognition worsened in some participants, however there was a general under representation of those living with dementia across many of the studies, because this was a study exclusion criterion featured in many of the studies. Some studies have captured vicarious data through staff, family, or caregivers, but the voice of the individual is missing for this important group and there is scope for further research which is needed for those living with cognitive impairments (Barguilla et al., 2020; Page, Davies-Abbott, 2021). This review has underscored that the spiritual needs of many aged care residents were unmet during periods of isolation and lockdown, possibly leading to further existential unmet needs. There is a general lack of consideration for this domain of quality-of-life, and researchers may underestimate its importance in this context. Wider literature does acknowledge that spiritual care in health service provision is largely unmet irrespective of clinical setting (Swift, 2020). There is scope for further research in this area to explore the role of Chaplaincy support during the COVID-19 crisis (Drummond & Carey, 2020; Jones et al., 2020).

Residents often agreed with the concept of restrictions to protect them, however the facilities often felt like prisons, and this evoked unpleasant war time feelings. Due to public health restrictions, there were delays in delivering essential multi-disciplinary care services including medical visits, sensory services, and physiotherapy. Future health policy regarding the aged care sector must include measures to ensure that this population is no longer deprived of essential services. All these important insights have important implications for nursing practice and rehabilitation following the consequences of COVID-19.

5 | LIMITATIONS

Firstly, the results and findings are from the perspectives of older people in RACF across the globe, however many countries may not have been represented due to the English language inclusion criteria. Secondly, the findings may not be transferable to those residents with dementia as this sub-group was grossly underrepresented in this review. Thirdly, due to the nature of the COVID-19 pandemic studies were conducted at various times in different countries, some believed they were experiencing the 'peak' of the wave; however, we now know that things became a lot worse for many over the time course of the pandemic.

6 | CONCLUSION

It is highly plausible that further outbreaks and stronger variants or future pandemics may prompt knee-jerk reactions from public health departments and governing bodies to continue to restrict and lockdown facilities. Public health COVID-19 outbreak policy makers, nursing and other healthcare professionals working in RACF globally should reflect upon these findings and will need to consider the benefit verses risk debate given the findings of this review. These

findings have clearly shown that it is vital that policymakers consider all quality-of-life domains not solely survival rates. It is a basic human right for all individuals to be able to remain active, physically, mentally, socially, and spiritually, in a safe environment.

7 | IMPLICATIONS FOR GERONTOLOGICAL NURSING

Perspectives from all aged care staff including multidisciplinary roles such as Chaplains, social workers, carers, and nurses would be an invaluable insight into the segregated world of the aged care facilities during a global pandemic. Investigating how this workforce cared for older people in RACF during time of lockdown, restrictions and strict infection control measures will provide insight into barriers and facilitators to optimise holistic care in the future, especially for residents with dementia or receiving palliative care. Identifying gaps, errors and successes, key stressors, and learning how to make things better for the 'next wave' or future pandemics will be prudent for any public health department and policy makers. Perspectives from family members on how the restrictions impacted them and their loved ones in RACF during the COVID-19 pandemic will provide important insights for caring for the family during periods of turmoil. Research should investigate the role of technology in maintaining communication and social relationships.

AUTHOR CONTRIBUTIONS

Catherine Paterson: Conceptualization, Methodology, Validation, Screening, Data Extraction, Formal analysis, Interpretation, Writing Original draft, Writing—Reviewing & Editing, Supervision. Nikki Jackson: Conceptualization, Methodology, Screening, Data extraction, Writing—Reviewing and Editing. Murray Turner: Methodology, Validation, Screening, Data extraction, Formal analysis, Interpretation, Reviewing and Editing.

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CONFLICT OF INTEREST STATEMENT

None to declare.

DATA AVAILABILITY STATEMENT

The data has not been previously presented orally or by poster at scientific meetings.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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Supplementary Table 1 Database Search Strategy

Five databases (APA PsycINFO (via EBSCOhost), CINAHL (via EBSCOhost), Medline (via EBSCOhost), Scopus, and Web of Science Core Collection) were searched on 8 June 2022, to identify relevant studies. An English language limiter was applied to the initial results of each search.

Search terms and number of results by database:

APA PsycINFO (260)

((economic OR emotional OR holistic OR "person-cent*" OR physical OR social OR spiritual) AND (coronavirus OR cov-19 OR covid-19 OR 2019-ncov OR sars-cov-2) AND ("aged care" OR "care at home" OR "community care" OR "community setting" OR "home care" OR "home health care" OR "long term care" OR "nursing home*" OR "residential care"))

CINAHL (717)

((economic OR emotional OR holistic OR "person-cent*" OR physical OR social OR spiritual) AND (coronavirus OR cov-19 OR covid-19 OR 2019-ncov OR sars-cov-2 OR (MH "COVID-19") OR (MH "COVID-19 Pandemic") OR (MH "SARS-CoV-2")) AND ("aged care" OR "care at home" OR "community care" OR "community setting" OR "home care" OR "home health care" OR "long term care" OR "nursing home*" OR "residential care" OR (MH "Home Health Care+") OR (MH "Nursing Homes+") OR (MH "Nursing Home Patients")))

MEDLINE (971)

((economic OR emotional OR holistic OR "person-cent*" OR physical OR social OR spiritual) AND (coronavirus OR cov-19 OR covid-19 OR 2019-ncov OR sars-cov-2 OR (MH "COVID-19") OR (MH "SARS-CoV-2")) AND ("aged care" OR "care at home" OR "community care" OR "community setting" OR "home care" OR "home health care" OR "long term care" OR "nursing home*" OR "residential care" OR (MH "Home Care Services+") OR (MH "Nursing Homes+")))

Scopus (1990)

TITLE-ABS-KEY (((economic OR emotional OR holistic OR "person-cent*" OR physical OR social OR spiritual) AND (coronavirus OR cov-19 OR covid-19 OR 2019-ncov OR sars-cov-2) AND ("aged care" OR "care at home" OR "community care" OR "community setting" OR "home care" OR "home health care" OR "long term care" OR "nursing home*" OR "residential care")))

Web of Science Core Collection (582)

TS= (((economic OR emotional OR holistic OR "person-cent*" OR physical OR social OR spiritual) AND (coronavirus OR cov-19 OR covid-19 OR 2019-ncov OR sars-cov-2) AND ("aged care" OR "care at home" OR "community care" OR "community setting" OR "home care" OR "home health care" OR "long term care" OR "nursing home*" OR "residential care")))

Supplementary Table 2. Quantitative Data

Author and Year	Social Well-being impacts	Physical Well-being impacts	Psychological Well-being impacts	Cognitive Well-being impacts	Spiritual Well-being impacts	Environmental Well-being impacts
Arpacioglu, S et al., 2021	Satisfaction with life (SLS) scores were significantly higher in those meeting with children or grandchildren more than 2 hrs per week during the covid-19 pandemic (P<0.05)	Not reported	NH residents had significantly higher Turkish Death Anxiety Scale (TDAS) (P<0.05) and lower life satisfaction levels than CD older adults during the pandemic (P<0.05). Increase in depression and death anxiety was found to predict the decrease in life satisfaction in older adults during the pandemic.	Not reported	Not reported	Not reported
Cheung, G et al., 2021	Not reported	No immediate negative impact on older Māori and Pacific Peoples.	New Zealand European residents in ARC reported more severe depressive symptoms during the covid-19 lock down period of 2020 than in the comparative period in 2019. (2020: N=785, 6.9% 2019: N=779, 6.3%). All ethnicities reported an increase in moderate depressive symptoms during the 2020 covid-19 lockdown period.	Not reported	Not reported	Not reported
Cortes Zamora, E et al., 2021	Not reported	There were higher levels of disability observed in basic activities of daily living (BADL), worse ambulation, higher frailty levels, and higher malnutrition risk among residents with covid-19. 47% of residents underwent a decline in Barthel Index from their baseline levels indicating	During the covid-19 pandemic 57.7% of residents (N=124) presented with GDS-5 scores >2 suggesting clinically significant depressive symptoms. 29.3% (N=63) of residents presented HADS scores > 11 points compatible with clinically significant anxiety symptoms. 19.1% presented TOP-8 scores>12 suggesting clinically significant PTSD symptoms and 93.0% of residents presented IES-A scores >2 indicating sleep disturbances.	Not reported	Not reported	Not reported

		a functional loss during this period.				
El Haj, M et al., 2020	Not reported	Not reported	Participants reported higher levels of depression during covid-19 restrictions (M=14.21) than before (M=12.34). Participants reported higher levels of anxiety during covid-19 restrictions (M=13.24) compared with before (M=11.38).	Not reported	Not reported	Not reported
Huber, A & Seifert, A 2022	25% of residents in Long-term care facilities (LTCF) evaluated themselves as lonely. Female residents (p<.01) with lower values of joy in life (p<.000) and life satisfaction (p<.000), and those who were not satisfied with the manner in which their care home coped with the covid-19 pandemic measures (p<.000) significantly felt lonelier than males.	Not reported	Not reported	Not reported	Not reported	Not reported
Levere, M et al., 2021	Not reported	During the height of the pandemic substantial weight loss represented a 150% increase compared to the average time periods prior to the pandemic. NH residents experienced a significant 6% increase in episodes of incontinence during the covid-19 pandemic	The percentage of NH residents with depressive symptoms during the pandemic increased 15% compared to the period prior to the pandemic.	During the pandemic cognitive function scores spiked by 0.11 points indicating a significant 5% increase (equating to a decline in cognitive function)	Not reported	Not reported

		compared to a similar period in previous years.				
Pereiro, A et al ., 2021	Not reported	The general pattern of age-related functional decline was not significantly altered by the strict lockdown period due to covid-19.	There was significant increase in depressive symptoms in the post-lockdown measurement, but this measurement difference disappeared when the frequency of social contact was included as a co-variate.	The general pattern of age-related cognitive decline was not significantly altered by the strict lockdown period due to covid-19.	Not reported	Not reported
Perez-Rodriguez, P et al., 2021	Not reported	Functional decline after the first wave of covid-19 and subsequent lockdown, was detected in 20.2% according to the BI and in 18.5% according to functional ambulation categories (P<0.001). Malnutrition increased from 20% to 56.8% after the first wave of covid-19 according to the MNA-SF. Higher levels of malnutrition were noted in individuals with covid-19 (P<0.001). Weight loss was observed in 167 residents (38.4%) and the median weight loss was 2.1kg	A significant increase in the prevalence of depression (11.1% to 54%) after the first wave of covid-19 and subsequent lockdown (P<0.001). The onset of depression after the first wave of the pandemic appeared in 164 of 344 (47.9%) of residents' who did not have prior depression (P<0.001).	Cognitive status after the first wave of covid-19 and subsequent lockdown, worsened by 22% and 25.9% according to the GDS (P<0.001) and MEC (P0.01), respectively.	Not reported	Not reported
Savci, C et al., 2021	MMSE score, Fear of Covid Score (FCV-19S) score and LSE (Loneliness Scale for the Elderly) significantly affected scores on the social relations score.	Being male, history of chronic disease, MMSE score, and changes in sleep pattern during the covid-19 pandemic, significantly affected	The mean FCV-19s score of the older adults residing in a nursing home in Turkey during the Covid-19 pandemic indicates that the fear of covid-19 level was moderate (19.13±4.28).	MMSE score and LSE score significantly affected scores on the mental dimension during the covid-19 pandemic (p<0.01).	Not reported	MMSE score, FCV-19S and LSE scores significantly affected scores on the environmental dimension (p,0.01).

		scores on the physical dimension QOL scores (P<0.01)	Older adults residing in shared rooms in a nursing home in Turkey during the covid-19 pandemic had a mean LSE score of 8.92±4.56 indicating that the level of loneliness was low.			
Solic, M et al ., 2021	10.2% of elderly residents experienced less contact with their families during the covid-19 pandemic. 96.9% of residents are using modern forms of communication to stay in touch with others. Residents who contacted their families and significant others during the pandemic crisis as often as before reported higher levels of social support. Individuals who perceive their social support as weak experience a higher level of loneliness.	Not reported	99% of residents were familiar with the occurrence of covid-19. Only 4.1% felt fear of the covid-19 virus and 96% felt protected living in the nursing home.	Not reported	Not reported	Not reported
Srifuengfung, M et al ., 2021	70% of older adults living in LTC during the covid-19 pandemic reported a moderate to severe impact on familial and external provider relationship. 60% reported a moderate to severe impact on their relationships with others living in the centre.	The degree of health impact was reported to be moderate to severe by 68% of respondents mainly due to difficulty seeing a physician.	Surprisingly, even though covid-19 has had a significant impact on the lives of older adults, most (70%) reported no or mild psychological stress.	Not reported	Not reported	The most impacted area experienced by OA living in LTC during the covid-19 pandemic was finance. 82.5% reported a moderate to severe impact due to decreased financial support from outside the centre. 76.5% of older adults living in LTC during the covid-19 pandemic reported a moderate

						to severe impact on freedom of living.

Abbreviations.

NH: Nursing Home; **CD:** Community Dwelling, **MMSE**: Mini Mental State Exam; **QOL**: Quality of Life; **LSE:** Loneliness Scale for Elderly; **ARC:** Aged Residential Care; **LTCF:** Long-term Care Facility; **LTC:** Long-term Care; **OA:** Older adult; **BI:** Barthel Index; **GDS:** Global Deterioration Scale; **MEC:** Lobo's Mini-Examen Cognoscitivo; **MNA-SF:** Mini-Nutritional Assessment- Short Form.

Supplementary Table 3. Qualitative Study Findings and Illustrations

Authors: Ayalon, L Avidor, S 2021					
Findings (themes in papers)	**Illustrations (Page number)**	**Evidence**			**Finding number**
		Unequivocal	**Credible**	**Unsupported**	
Us vs. them: Others are worse off.	"Those who are alone (in the community), my friends who are alone, they are simply jealous of us, because they are saying "You live in a cage, but a cage of gold because you are being spoiled' (pg 666).				1
	'Yes- and we are in a good position because we are two and we have a comfortable apartment, but let's say, 70% of the residents here are lonely" (pg666).				2
Us vs. them: power imbalance	People had died in the CCRC but the resident received no information				3
We have become prisoners in our own age	"You felt as if you were being held in prison. Strongly, on the other hand, possibly, because of this, no one here was infected -maybe' (pg666).				4
	'I have been watching myself trying not to let depression in, but it (lockdown) was depressing. From that period, when I was7-8 years old, all alone , among strangers, in a threatening world. I have learned how to block my feelings when I needed to. So- that girl has become my counsellor during lockdown. Even now, the girl is saying: 'I am getting over this. I am getting over this. I am not thinking about this, I am shutting this out. I reorganise things". Holocaust survivor (pg666).				5
Authors: Davies-Abbott, I Hedd Jones, C Windle, G 2021					
Findings (themes in papers)	**Illustrations (Page number)**	**Evidence**			**Finding number**
		Unequivocal	**Credible**	**Unsupported**	
Autonomy	"I mean we, we haven't been able to decide whether we want to risk going to see our families, we're just forbidden to go out" (pg150).				6
	" I even went through a little stage where I was thinking, is there another way to live where I don't have to come back in" (pg150).				7

	"We're here until, unless we go worse and we go in a home, a, a nursing home, we're here until death and I, I said, one way or the other, are we going to be deprived living until we die" (pg150).				8
	Care staff accepted Patti's capacity to make decisions regarding her own care and treatment although Patti felt excluded in decisions made about the care home's overall pandemic response (pg153).				9
Fears	" I suppose just the fact that it could just go right through the place and everybody could drop like flies […] you don't really expect to come through the other side of covid" (pg151).				10
	"To think that winter's coming on, so I thought, Am I going to be able to go out this summer at all? Can I go and sit in my daughter's garden and be looked after? (pg150).				11
Keeping connected	Patti described the lack of close contact as the most damaging aspect of lock down on her over-all quality of life (pg151).				12
	Social restrictions included an inability to attend to her religious needs in a church setting (154).				13
Keeping safe	"Just what bothers me is the fact that if somebody brings it in, we've got no choice as to whether we want to risk it or not, have we? Its not our choice then, is it? If I choose to go out, but I know that if I choose to go out, I wouldn't be able to come back in" (pg152).				14
Other people living with dementia	Behaviour of some residents was more difficult to accept due to the risks presented by the virus: " I don't like people coming in my room, especially when they're at the stage where they , they're fiddling and messing with everything and I certainly don't like that since Covid" (pg152).				15
Authors: Ho,K et al., 2022					
Findings (themes in papers)	**Illustrations (Page number)**	**Evidence**			**Finding number**
		Unequivocal	**Credible**	**Unsupported**	

A deprived sense of self-significance in a familiar world contributes to older adult's disconnection with prior commitments.	It is important for older adults to feel functional and to be functional for themselves and for others. During the covid-19 pandemic, some individuals felt a biological decline and developed a conscious awareness of their personal integrity: "I am valueless to society" (pg.283). Older adults loose their own significance when they are no longer functional. Older adults view themselves as burdensome, no longer constituting a meaningful existence.				16
	"I am still lonely. My daughter and I are in two parallel worlds" (pg.284). "I am not a significant one for others. I am not afraid of getting the disease [covid-19]. I hope I get it, then everything is ended" (pg.284).				17
From collapse to dissolution of self-understanding **(ties with the familiar world have been broken)**	The covid-19 pandemic generated a sense of vulnerability and destabilised ties with the familiar world for these older adults. "I am worried about the safety of my family", "My mind is not peaceful. The experience of SARS was already disturbing. It's a pandemic now. I fear. I don't want to lose anyone" (pg.284).				18
	Older adults' anticipation of losing meaningful relationships due to the covid-19 pandemic awakened them to the unsettling fact that human existence was finite. "I am worrying about myself. If I get the covid-19, I am afraid of no one care about me. It will be miserable" (pg.284), "Group activities are cancelled, and my family cannot visit me. The free time is really disturbing. I have nothing to do every day, but my mind is not peaceful. Every peace of information about covid-19 makes me anxious. Without family and group activities, I keep the anxiety within me. I keep silent and bear it. My impression of the past few months is of loneliness" (pg.284), "I have several children but end up live alone in a residential care home. This disease [covid-19] further keeps me alone. I don't know the				19

	reason of surviving. I don't know what I am for…"(pg.285).				
Restoring meanings by establishing connections with entities (seeking alternate ways to develop meaning and purpose)	"Without church activities, I feel lonely because we cannot group together and cannot update each other. It's an environment that cannot be replaced by telephone calls. Luckily, I like reading the bible. When I read the bible, I pray. God listens to me, and I hear His voice. I am reassured"(pg.285).				20
	Some residents expressed how being hugged embodied being cared about: "My home is here. The nurses are very good. They are concerned about my feeling of being trapped every day. They hug me. They talk with me. They encourage me to reach out within this home, of course, wearing a mask. I don't feel anxious here. I feel loved" (pg.285).				21
	Older adults developed active engagement in their lives through alternate means: "I got a tablet from the nurse-in-charge. It helped me a lot. At least, I am not so tense because I can play mah-jong on the tablet. My mind focuses on it. It means that my mind is peaceful, and thinking is not chaotic", "During the covid-19 pandemic, I plant in the backyard of this care home. When I feel lonely, I look at the plants. They grow day by day. It's fulfilling"(pg.285).				22
Authors: Ickert, C Stefaniuk, R & Leask,J 2021					
Findings (themes in papers)	**Illustrations (Page number)**	**Evidence**			**Finding number**
		Unequivocal	**Credible**	**Unsupported**	
Covid-19 response and knowledge	Residents accessed information about covid-19 and changes to public health rules in a variety of ways, with some residents describing family members or centre staff as their primary source of information. At some centres, residents described gaps or inefficiencies in sharing the information, with one resident observing that "they don't tell you anything around here", and				23

	another noting that “the only time they answer you is when you ask a question. Otherwise they are not forthcoming” One resident was asked how he found out that his centre was having an outbreak, and he responded “actually my son told me”(pg.1549)				
	Several residents described observing residents with cognitive impairments waiting for family members visits that were not going to happen, noting: “They don’t get it, they don’t understand, they wait a week, a week for their families to show up. Everyday you know. Very sad, it’s sad” (pg.1550). “Sure, I miss the visits from my family, but I’m capable of understanding why its necessary versus some residents here who are incapable of understanding why this has to be. And then there’s some that you can explain it over and over to them and half an hour later they’re gone” (pg.1550). “They get agitated, and they don’t understand, and they quite often will verbally lash out at some, at staff” (pg.1550).				24
Centre Operational Response (public health policy enactment at their centres)	Residents described the testing regimes as unpleasant but necessary. Residents described the staff enforcing the public health social distancing guidelines stating that staff “were kind of babysitting you, or watching you, so you don’t get closer than 6feet away”, “I don’t like the idea of having a chaperone there. I don’t want a chaperone to overhear what I think of the chaperone”, “bugging me because I happen to be sitting 5 feet from somebody instead of 6 feet away” (pg.1550).				25
Living with Rules and Restrictions	Day to day life changed significantly when covid-19 public health policy was implemented at the centre. No social program meant that there were no activities, one resident was asked by a new room mate “what do you do here during the day?” to which she replied “Well, nothing, because we don’t do anything anymore. We used to have a recreational programme” (pg.1550). “No				26

	activities, they're scared to do anything", "you have to make your own fun" (pg.1550). Residents noted that you can't be spontaneous and go out due to isolation requirements when leaving the building.				
	Residents noted changes to their dining experience; "only two people are allowed at the tables, which were 6 feet apart. So the rest of the people that couldn't…or numbers couldn't fit them into the dining room, they ended up eating at the bedside", "Well they've had to space everybody out in the dining room. So that limits the number of people that they can have in the dining room" (pg.1550). The change in dining experience impacted residents' ability to socialise: "When they used to sit people together, we'd chat about what's going on and, you know, the group and all, but now…none of that" (pg.1550). However necessary the covid-19 restrictions were, the effect was that: "socialising was really hard", "Four months we've spent in our rooms, and the dining room was about the only place we could go. That was also a thing: we had to sit two to a table, they broke up our table. We had four people sitting there and then we had two" (pg.1550).				27
	Due to restrictions, residents could not attend physiotherapy sessions, in an effort to stop her own physical decline one resident stated" I'm working on improving my own" by exercising alone in her room (pg.1550)				28
Wellbeing	Residents described the myriad of impacts of the pandemic on their wellbeing. Residents discussed the impact on their physical wellbeing, such as reduced movement leading to functional decline or lost weight. "I've lost weight" (pg.1550)				29
	Residents' discussion of wellbeing predominantly focused on their psychosocial wellbeing. Common feelings described were sadness, loneliness, fear, and frustration. "I'm lonely here and sad", "As time goes on,				30

	its becoming, like there's a lot more people that's depressed, and I cry at night" (pg.1550).				
	When speaking about those with dementia: "For the rest of the residents, they sat in their chairs and just looked lost", "you can just see it, the mood of the people" (1550).				31
	Residents felt like public health rules impacted their wellbeing more than those living outside in continuing care: "When you're in here, you're not like other people. They go out and do things. We're stuck in here. So all the little things we do, for enjoyment, well, you take them away. So it's a lot different for us than it is the average Joe" (pg.1551).				32
	Residents observed the impact on residents with dementia was greater than on themselves: "They can't use their arms, they can't use their fingers… they don't have the mental capacity to make a phone call", "I feel really, sorry for them… for a dementia patient I can imagine how frightening that would be…. When you were at the hospital you got used to your routines…. then all of a sudden, you're in a completely new environment. And you can't have your family visiting you on a regular basis" (pg.1551).				33
Criticism and Suggestions for Improvement	Residents had opinions about the public health measures: "I agree we should be kept from harms way", "It was strict, but again, I know why it had to be done", "Some of them say well I'm not happy about it. They are a little bit different, like I say. They're tired of it" (pg.1551).				34
	Residents want improvements in communication: "come and tell me what's going on", "Give me the option of meeting my family in the sunshine". Policy was enacted with little consultation with stakeholders.				35
Authors: Kaelen et al., 2021					
Findings (themes in papers)	**Illustrations (Page number)**	**Evidence**			**Finding number**
		Unequivocal	**Credible**	**Unsupported**	

Loss of freedom	During covid-19 lockdown measures, residents were often isolated in their rooms, this portrayed the notion of being separated from the outside world, where life goes on but theirs is put on hold: “More than my health, I really feel that it is my freedom that I have been robbed of and I find it difficult to bear”(pg.6), “It’s horrible to be locked up”, “it’s like being in a prison”(pg.6).				36
	Residents reported feeling “claustrophobic” , “becoming crazy” or “depressed”. They reported that the experience of being in lockdown during covid-19 was: “the most horrible period of their life” even compared to the period of World War II. “So the difference [between war and confinement] is that confinement was never there..[…..] people always had the freedom to go out, to go out freely. If you went out or if you stayed at home……there were no instructions” (pg.7).				
Loss of social life	During lockdown residents were not permitted to physically interact with other residents, hairdressers, support services and family members, and care workers had to remain distant. “ […] All right, we were locked up, we could not get out. We have nothing, nothing. And to finish this, my wife is unhappy over there and I am unhappy here too”(pg.8). “They [the staff] had no time anymore. They had to be very fast, and they disappeared quickly. For example, when they bring the lunch, they put the tray down and leave. And as my mind became a bit slow, I think about those questions I want to ask when they have already left the room” (pg.8)				
	Residents felt as if they had been “abandoned”. They described that the entire atmosphere had changed within the nursing home: it had become “cold”, “distant”, and there was “no more joy”(pg.8).				

	"We are social beings. One is not made to stay alone in one's room, it is enough to become crazy. We can read, we can watch television, but its not the same thing as living with others" (pg.8). "The lack of contact, I didn't hold anybody since….. I think the lack of physical contact is very hard. It's almost unhuman. It's not natural" (pg.8).				
Loss of distraction and stimulation	All recreational activities were cancelled during lockdown, creating a great sense of boredom: "And when you are very old, all of this (activities) stimulates you strongly. Basically, there is no stimulation anymore, only what you create yourself, going for a walk and all that, if not, there is nothing left. There was nothing anymore" (pg.8)				
	"And with the physiotherapist I do my exercises. In the end we have pain everywhere, because of staying inactive, we miss it, for 3 months 3 and a half months, nothing" (pg.8).				
Loss of autonomy	An absence of proactive communication and information sharing about the covid-19 situation left residents feeling unrecognised, forgotten, and deprived of the opportunity to share their struggles and concerns. "It is this that I cannot stand, it is unbearable. They (the staff) take you for pawns, for children, you see. They do not ask your opinion, and its worse during the covid [….]. We are very easily infantilised" (pg.8). "It doesn't matter what you as a resident say, they don't even hear it" (pg.8).				
	Residents were not included in any decision-making processes, nor were they asked for their opinion: "Our input was never asked" (pg.9). There was no platform where they could ask their questions, raise their concerns, or propose any suggestions. Being excluded from any decision-making made them feel losing their autonomy.				

	Residents began to consider if the lockdown periods were “too long”, “unfair” and “illogical” as the general population were aloud to go out but residents were not: “I personally think it’s an exaggeration. Yes, I know that in other homes 50 people have died, but aren’t they happier, do you think it’s fun to live here? They overprotect us, that’s not what we want. What we want is to be free” (pg.9).				
Perception of own wellbeing	Most residents had a resilient and accepting attitude at the beginning of the lockdown. But as the measures continued, they became increasingly angry and stressed. Covid-19 took away their freedom and they had no perspective on when they would be able to see their family and friends again. This lack of perspective was accompanied by a deep existential uncertainty. It took away hope and trust of the future: “I am at the end of my rope”(pg.9)				
	Feelings became heavier, more hopeless: “It was going well I can say for 2 months, I held out. But a while ago it changed, now the morale is zero. But completely flat. I don’t feel like doing anything anymore, I have to force myself to do something to forget that I’m locked up but its not right. You change. But its very subtle, I can’t explain how change. But I don’t feel anymore like I did at the beginning” (pg.9) “We don’t have a life anymore since covid-19. Yes, I think more and more about……suicide because I think I’m at the end of a depression if it continues. Before I go to sleep, I wish I wouldn’t wake up the next day” (pg.10)				
	Several residents reported cognitive and physical decline. They experienced more tiredness, loss of appetite, and a loss of mobility. Residents said they felt that their memory was letting them down: “It deteriorates me a bit , as if I start losing my mind, forgetting words and so on” (pg.10)				

	Residents felt fear, but not fear of becoming infected with covid-19, they felt fear of being locked-up and isolated again: “No, I am not afraid of covid-19…. I’m afraid if its going to happen again and we have to go in quarantine again”, “A second lockdown will be horrible, I don’t want to think about that, because you know, I may die from one day to the next, so I prefer to be free” (pg.10).				
Authors: Lood, Q Haak, M & Dahlin-Ivanoff, S 2021					
Findings (themes in papers)	**Illustrations (Page number)**	**Evidence**			**Finding number**
		Unequivocal	**Credible**	**Unsupported**	
It’s like living in a bubble	The interpretation of the participants experience of living in a NH during the covid-19 pandemic was that it was somewhat a world of its own. Some felt safe and secure in terms of virus transmission but at the same time isolated from the outside world. Older adults were not afraid of getting the virus since they were so old. They are living one day at a time. This was described as having no choice but to accept the situation, even if being old and frail was experienced as tough.				
	Everyday life in the NH involved not having the freedom to choose for oneself what to do, with whim and when. There was a perception that there was simply no other option: “The freedom. I am dependant you see. So, I cannot choose… Nobody is allowed to go out, nobody is allowed to come in”(pg.4).				
	They experienced health deterioration, both because of age and frailty, and because of the pandemic related restrictions with few opportunities to move about, to go outside or to receive visitors without assistance from staff.				
Authors: Murphy, E Doyle, M McHugh, S Mello, S 2022					
Findings (themes in papers)	**Illustrations (Page number)**	**Evidence**			**Finding number**
		Unequivocal	**Credible**	**Unsupported**	

Residents' perception of their environments	Ensuite facilities were deemed important to maintain dignity: "Two toilets for all the ladies, which was very, very bad…you often had to queue" (pg.30)				
	Personal control of their environments gave residents a feeling of ownership and autonomy during covid-19: "Your own room, your own privacy, your own thing" (pg.30).				
	Even for those who could not easily go outside, a view with green space was valued: And I just looked out there and saw the mountains I couldn't believe it. Oh my God, it was just heaven" (pg.30).				
Loss	Public health restrictions during covid-19 prevented residents going to church: "On a Sunday, going over to the church" they spoke of: "missing a bit of fun" and "everybody used to talk to everybody else… it's not the same nowadays" (pg.31).				
	Residents described the loss of visitors during covid-19 as a particular burden, causing loneliness and isolation: "Nobody comes in here, nobody except my family and they can't even come in now on account of the flu virus" (pg.31). Patio visits were implemented but residents missed physical contact. Visits were difficult through closed windows: "They were sad because you couldn't be near your loved ones and be close to them and hug them" (pg.31)				
	Residents described the experience of knowing fellow residents were dying: "You'd know someone wasn't well going down… it wasn't upsetting, the nurses would tell you when they were gone" (pg.31). Others spoke of their grief: "She was a real lady…. I miss her so much"(pg.31).				
	A resident whose wife had died during that year spoke tearfully about due to the increased covid-19 restrictions, he had not yest been able to visit her grave (pg.31).				

	When asked to describe how covid-19 had affected them residents replied: “Well the first thing about that was, no matter where’d you’d be, was fear…that was the only thing, the fear”. Residents found themselves: “Thinking about it all the time”, “ I know how serious it is, I listen to the news all the time”, “I am afraid to go into crowds. Yet I don’t like being on my own”(pg.31).				
Relationships	Patio visits during covid-19 allowed residents to see their families. Others were satisfied with phone communication; “My family ring me all the time”, some utilise iPad: “Mary shows them to me on the tablet thing, it’s nice to see my sister and brother”(pg.31).				
	Positive relationships with staff were a source of comfort during covid-19. Many perceived staff as protectors during the pandemic: “ They work very hard at keeping us safe”. One resident spoke of feeling “safer here than I would at home”. When speaking about the staff: “They’re the most wonderful crowd of people I’ve ever met in my life” (pg.31),				
Resilience	Most residents accepted the many hardships of the past year living with covid-19 and the pandemic restrictions. “I don’t worry about [covid-19], no, I am after having a good life. I’m 90 as you know… I have had a good life”, “It’s there and you would be afraid of it…but I don’t worry much about it” (pg.31).				
	Residents accepted the restrictive pandemic measures: “That was tough. But at the same time, you knew that was for your own good and your own safety and I wouldn’t complain” “You have to respect it as the way it is now because of the virus” (pg.31).				