OPTIMIZING OUTCOMES: HOW LONG-TERM CARE POLICIES CAN BALANCE INFECTION PREVENTION WITH MAINTAINING HOME-LIKE ENVIRONMENTS FOR RESIDENTS WITH BEHAVIOURAL SYMPTOMS

by

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Dalhousie University is located in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq. We are all Treaty people.

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ABSTRACT

The health benefits of homelike care environments are well established in the literature and but may become challenging to maintain during outbreaks of infection in long-term care ("LCT") settings. The aim of this research is to contribute to a broader understanding of the likely impacts of COVID-19 related restrictions on long-term care on residents' health and wellbeing. This is done through examining (1) what factors contribute to a sense of home for residents in long-term care and how do these factors impact residents' health and wellbeing and (2) what restrictions were imposed in LTC facilities in response to the pandemic, and how these restrictions were likely to impact residents' feelings of being at home. These questions are answered through a detailed content analysis of (1) peer-reviewed literature on the impact of homelike environments on resident outcomes, (2) public statements and reports in the media on this issue, (3) in-depth, narrative reports of resident lives in long-term published by social science and nursing professionals working in the field, and (4) COVID-19 Management in Long-Term Care Facilities Directives released by the Nova Scotia Department of Health and Wellness (Bernard et al., 2017).The results of this research suggest that by promoting key factors such as maintaining socialization, regular routines, engagement in meaningful activity, and autonomy in distraction free environments, even under restrictions relating to disease outbreaks, can optimize the health and wellbeing of residents.

LIST OF ABBREVIATIONS USED

DHW	Department of Health and Wellness
LTC	Long-term care
PCR	Polymerase chain reaction
PPE	Personal protective equipment
RCU	Regional Care Unit

CHAPTER 1 INTRODUCTION

It is widely recognized that home-likeness is one of the most effective ways to optimize health outcomes for individuals in care settings, as a sense of home is reported to create an ideal healing or therapeutic environment (Collier et al, 2015, p. 698-700; Molony, 2010, p.292; Robinson et al, 2010). For seniors with health issues and their families, entering long-term care ("LTC") is often a difficult but necessary decision. The COVID-19 pandemic made this decision even more challenging, and threw into the spotlight both the pre-existing issues plaguing long-term care facilities and the precarious nature of the homelike environment in institutional care settings under restrictions related to infection prevention and control (Canadian Union of Public Employees, 2022; Chu and Stamatopoulos, 2022; Day, 2022; Gowriluk, 2020).

On January 30th, 2020 as the World Health Organization declared COVID-19 a public health emergency of international concern, early reports were emerging from China that the virus posed a greater risk of severe illness and death to the elderly (Nolen, 2021). Concerns for seniors, particularly those in institutionalized settings, grew in Nova Scotia as the first serious COVID-19 outbreak in the province occurred at Northwood Campus, a long-term care facility in Halifax. Within a matter of four months, 246 residents and 99 staff at Northwood had tested positive for COVID-19, and 53 of the total 63 COVID-19 deaths that had occurred in Nova Scotia were Northwood residents (Nolen, 2021). Protecting long-term care in particular became a primary focus of the government's COVID-19 response.

Throughout the pandemic, *The COVID-19 Management in Long Term Care Facilities Directives* were frequently updated as a comprehensive document setting out restrictions applied to all long-term care facilities, both private and public, in Nova Scotia. Of particular importance in these documents are those restrictions limiting visitors, introducing cohorting, social

distancing and gathering limits within the facilities, enforcing isolation requirements upon admission or readmission to the facilities, and those pertaining to environmental services such as increased cleaning (Government of Nova Scotia, 2020). It is these restrictions that appear most likely to limit the factors contributing to a sense of home for residents. Media reports on the impacts of these restrictions, namely visitor restrictions, on the mental health of residents quickly emerged. Many families expressed concern that their loved ones who lived in long-term care were experience the final years of their lives without access to family or friends, claiming the government had overlooked the needs of this vulnerable population (Bains, 2020; Ryan, 2020; Thomas, 2020).

Now that COVID-19 restrictions have ended for both the general public and within the long-term care industry, studies about the impact of infection prevention and control efforts remain relevant. Long-term care residents are vulnerable to regular but severe outbreaks such as influenza and norovirus (Chen et al., 2017, pp.26-33; Lansbury et al., 2017, pp.356-366; Nova Scotia Department of Health and Wellness, 2016, p.1). The ability of long-term care administrators to foster and help nourish a sense of home for residents even during infection outbreaks would not only help to optimize resident health and wellbeing, but also provide reassurance to families that their loved ones are safe and comfortable in their living environments.

For this research project, I have explored how COVID-19 restrictions impacted the health and wellbeing of long-term care residents in Nova Scotia, with particular interest in the effect of the restrictions on residents' feelings of being "at home" in care facilities. To engage with these topics, I undertook a detailed content analysis of (1) peer-reviewed literature on the impact of homelike environments on resident outcomes, and (2) public statements and reports in

the media on this issue and (3) in-depth, narrative reports of resident lives in long-term care published by social science and nursing professionals working in the field, and (4) COVID-19 Management in Long-Term Care Facilities Directives released by the Nova Scotia Department of Health and Wellness ("DHW") (Bernard et al., 2017). As the majority of this research was conducted in 2021/2022 while restrictions still barred unnecessary visitors from entering long-term care facilities in Nova Scotia and accessibility of peer-reviewed literature on the direct impact of restrictions on long-term care residents was limited, the data for this project was limited to pre-existing literature. Nonetheless, timely exploration of the likely impacts of COVID-19 related restrictions in long-term care on residents' health and wellbeing located within sociological knowledge frameworks was warranted in order to critically engage with the effectiveness of the efforts being made to protect the health and wellbeing of long-term care residents (Harrington and Estes, 2008; Mechanic, 2007; Plumer, 2022, p.158; Shenton, 1927, p.177).

1.1 LONG-TERM CARE IN NOVA SCOTIA AND THROUGHOUT CANADA

Institutionalized care, specifically in the form of the long-term care facilities that we see today that house primarily the elderly, emerged around the 1920s with private facilities opening to provide long-term, around-the-clock care for seniors and those suffering from age related illnesses (Emodi, 1977, pp.8-9; Mah &Gallup, 2021, p.77-79). As the demand for such long-term care services grew quickly, issues arose that continue to plague long-term care facilities today, including an insufficiency of the beds, services, and facilities necessary for the specialized care required by residents (Emodi, 1977, p.l1; Mah &Gallup, 2021, p.79-80). These issues forced a narrow focus on the immediate physical needs of residents, to the detriment of meeting their

psychosocial needs, and contributing to ongoing health issues (Emodi, 1977, p.13). Today, the overemphasis of physical needs to the detriment of a holistic understanding of wellbeing that includes psychosocial considerations is referred to as clinicalization of care (Cowling et al., 2000, p. 16; Cowling et al., n.d; Cowling & Taliaferro, 2004, pp.55-56; Kagan et al., 2009, p.77). This concept, studied by both social scientists and health care professionals, is understood to exist when the human experience is viewed as a clinical matter, at the expense of human wholeness (Cowling, 2000, p. 16; Cowling & Taliaferro, 2004, p.55). The process of clinicalization ignores the complexity of human wholeness and relies primarily on diagnostic representations, thereby missing essential pieces of the human experience such as the wholeness and uniqueness of each individual, contrary to sociological theories of how health should be promoted (Cowling et al., 2000, p. 16; Cowling et al., n.d; Cowling & Taliaferro, 2004, pp.55-56; Kagan et al., 2009, p.77).

The risk of such challenges in care delivery leading to an overemphasis on purely physical care needs rather than psychosocial or mental wellbeing is addressed within the current *Nova Scotia Long-Term Care Facility Requirements* (2020) which seems to acknowledge the ability of policies supporting psychosocial health to increase quality of life for residents in long-term care. In doing so, the *Long-Term Care Facility Requirements* advocate for a holistic approach to resident wellbeing by ensuring their social and psychological needs are being met in addition to their physical needs (p.8). These requirements set out standards of care for both privately and publicly funded long-term care facilities in Nova Scotia, which collectively house of 8,000 residents in Nova Scotia (Department of Seniors and Long-Term Care, 2023).

While this commitment to meeting the social and psychological needs of long-term care residents in Nova Scotia sounds promising, it is important to recognize that the interpretation of

such a goal remains subject to government authority, and therefore, to the intertwining of market logic and governance that defines neoliberalism in Canada, allowing social programs and public policies to be evaluated in terms of their value rather than their benefits for the wellbeing of people (Badone, 2021, pp.390-393; El-Bialy et al., 2021, pp.2-7). In the Canadian health landscape, long-term care in particular has become commodified, as it is excluded from the definition of essential health services and therefore from Canada's universal health insurance, allowing a market-determined price to be assigned to the service (Leys and Hay, 2015, p.391).

In Nova Scotia, the commodification of long-term care services is offset partially, although not entirely, by the provincial government. The cost of long-term care for Nova Scotians is shared between the individual and the DHW with the individual paying for costs associated with accommodation such as the operation costs of the facility to which they are admitted, while the DHW covers costs associated with the delivery of medical care through paying the salaries of medical professionals. Standard accommodation charges are assessed annually by DHW and those who are able to pay the full amount will do so, while individuals unable to pay the full accommodation charges as set will undergo financial examination to allow them to pay no more than 85% of their annual income towards the cost of long-term care (Department of Health and Wellness, 2023).

This cost sharing approach remains problematic, however, as many individuals entering long-term care are already considered low-income or are at risk of becoming so. This is in part because low-income seniors are already far more likely to have restricted physical functioning, disabilities, or health issues that warrant care, and therefore are more likely to be admitted to long-term care facilities (Bernardi et al., 2021, pp.8-12; Cruickshank, 2013, pp.93-95). Further, as of 2019, 64.7% of long-term care residents in Canada were female (Statistics Canada, 2021);

while 10% of all women in Canada are considered low-income, the risk of experiencing poverty and low-income rises to 23% and 16.3% for women with disabilities and women over the age of 65, respectively (Fox and Moyser, 2018; Wall, 2017). Therefore, it is likely that the costs of the commodification of long-term care are disproportionately impacting low-income or impoverished Nova Scotians. This impact, in particular, warrants a sociological exploration of prominent issues arising in long-term care, such as the impact of the COVID-19 pandemic and resulting restrictions on the daily lives of long-term care residents.

1.2 THE MEANING OF "HOME"

Social scientists view both housing and homes as social determinants of health, particularly so for the elderly. Where the aging population lives, the care they can experience in their home environments, and their health and wellbeing are intrinsically linked (Collinge, 2021; Rolfe et al, 2020). Sociologists in particular emphasize that a comprehensive assessment of wellbeing looks not only at mental and physical health, but also the context in which it is experienced, specifically the environment and supports available (Collinge, 2021; Donald, 2009; Rolfe et al, 2020; Williams and Kitchen, 2012). When looking at the very concept of home, sociological scholars highlight that it is a complex and multi-dimensional phenomenon, that most often involves comfort, safety, and connection to others or a sense of belonging (Collinge, 2021; Douglas, 1993; Sommerville, 1997).

Molony (2010) conducted an interdisciplinary qualitative meta-synthesis on the meaning of home in the fields of anthropology and nursing that proves extremely useful for this research project. According to her meta-synthesis, home is both a place and a process, a dynamic construct that empowers both relationship building and self-recollection (pp. 295-301). Home is

empowering in that it is a place of personal power in which an individual can do what they want and have the freedom to interact with the environment as they so please, developing familiarity with the rhythms and rituals of the environment (pp. 301-302).

In contrast, gaining a sense of home after a transition such as relocation, change in health, or loss of function required self-reflection, in addition to redefining, reconciling, and reconfirming an individual's role and sense of self in the environment (pp.302-305). The impact of a transition such as this is so great that many studies address how a sense of homelessness can be experienced even within the context of a residential dwelling, as a result of disruptions in the social or physical environment, with the conditions of the transition and the milieu of the new environment facilitating or impeding the process by which an individual renegotiates a sense of home (Molony, 2010; Rowles, 1983; Wiersm, 2008; Zingmark et al., 1995).

Rowles et al. (2013) offer a similar analysis of the concept of home as a place, explaining that the idea of home is dynamic, consisting of ongoing personal and social processes influenced by social and historical contexts (p.110), but that there are a few central dimensions of feeling at home, including comfort, autonomy, security, and belonging, regardless of location (pp. 112 & 116). These dimensions are the result of the intimate relationships we have with the places that we call our homes, which we must recreate and renegotiate whenever we relocate, in order to once again feel at home. This process of recreating and renegotiating the intimate relationships we have with the places that we call home is referred to as place-making, and it plays a vital role in the ability of long-term care residents to experience home-like environments (p.110). These studies, taken together, provide a comprehensive, working definition of home for operationalization within this research project. Specifically, 'home' as it is understood by this

project is as a site of empowerment, security, and belonging in which an individual may interact with the environment and others however they so please.

1.3 HOME-LIKENESS IN LONG-TERM CARE

These theories on home, and the working definition that can be derived from them, can further be applied in the context of long-term care facilities. For residents of long-term care to feel at home, they must be able to successfully engage in place-making, to create and negotiate an intimate relationship with the new setting in which they live. Wada et al. (2020) suggests that the presence of personal objects and the ability to continue in familiar routines may be essential to the process of place-making upon relocation to institutional settings. While not all aspects of an individual's routine prior to relocation will continue, those most useful in creating a positive relationship with a new place should be supported. Continuation of routine, socialization, and engagement in meaningful activities are highlighted as particularly useful in the process of creating a sense of home following relocation to care environments (Wada et al., 2020, pp.1269-1271). Molony (2010) furthers the importance of socialization and activity engagement, noting that being known and knowing others frequently arose throughout her meta-synthesis as a core aspect in distinguishing "being home" from "not being home". Work or participation in activities such as church services, which allow residents to maintain socio-cultural roles, were also noted, included in portrayals of home as both a place of activity and rest (pp.302-304). The maintenance of sociocultural roles offers a way for long-term care residents to experience a sense of belonging, which as already noted, is essential to the concept of home, and such activities will feature heavily throughout this research project.

Emphasis on the role of a comprehensive assessment of wellbeing that looks not only at mental and physical health, but also the context in which it is experienced, specifically the

environment and supports available, will notably contrast throughout this project with the existence of clinicalized care environments (Collinge, 2021; Donald, 2009; Rolfe et al, 2020; Williams and Kitchen, 2012). To promote healing in long-term care facilities it would appear that balance is required between the degree of clinicalization required for medical care and the extent to which a sense of home is maintained. This is because, while homelike environments are thought to be the most therapeutic, highly clinicalized spaces are not likely to themselves facilitate a sense of home, and therefore, creating an environment that can offer both the clincalized care necessary and contribute to a sense of home should be ideal for residents (Cowling, 2000, p. 16; Cowling & Taliaferro, 2004, pp.55-56; Molony, 2010, p.292; Robinson et al, 2010).

1.4 BREAKING DOWN THE RESEARCH QUESTIONS

The aim of this research is to contribute to an understanding of the likely impacts of the COVID-19 related restrictions in long-term care on residents' health and wellbeing. To do so, I have parsed my research interest into two subsidiary questions, as follows:

1. What factors contribute to a sense of home for residents in long-term care and how do these factors impact residents' health and wellbeing?
2. What restrictions were imposed in LTC facilities in response to the pandemic, and how were these restrictions likely to impact residents' feelings of being at home?

To answer these questions the remainder of this thesis will proceed to examine (1) peer-reviewed literature on the impact of homelike environments on resident outcomes, and (2) public statements and reports in the media on this issue and (3) in-depth, narrative reports of resident lives in long-term care published by social science and nursing professionals working in the

field, and (4) COVID-19 Management in Long-Term Care Facilities Directives released by the Nova Scotia Department of Health and Wellness (Bernard et al., 2017). By developing a theoretical codeset of factors expected to relate to home, health, and wellbeing in long-term care environments and then applying that codeset to in-depth, narrative reports of resident lives and COVID-19 restriction policy documents, a fuller understanding of the likely impacts of the pandemic restrictions on long-term care on residents' health and wellbeing should be gained.

CHAPTER 2 LITERATURE REVIEW

This literature review was conducted largely on a wide set of peer-reviewed articles accessible through the sociological, anthropological, and nursing databases offered by the Dalhousie Libraries. As this literature review was conducted in 2021 and 2022, during which time the COVID-19 pandemic response in Nova Scotia was still evolving, media reports are used to supplement contextualizing information that would not have yet been available within peer-reviewed, academic articles. The goal of the literature review is to briefly summarize the available literatures on how a sense of home is experienced in long-term care, how a sense of home relates to resident health and wellbeing, and how the COVID-19 pandemic impacted long-term care residents.

2.1 A SENSE OF HOME IN CARE

Home is not just a place, rather it is a complex and shifting construct influenced by inhabitants, relationships, and the presence of social and cultural symbols (Collier et al., 2015, p. 698-700; Molony, 2010, p.292). The complex nature of home goes beyond a physical structure and includes the local community and neighborhood (Bigonnesse et al, 201, p. 358). This network of structure, community, and neighborhood further helps to shape personal identity (Bigonnesse et al, 201, p. 358). The process of creating and negotiating, and in the case of reloaction, recreating and renegotiating, the intimate relationships we have with the places that we call home is referred to as place-making, and this plays a vital role in the ability of long-term care residents to experience home-like environments. For residents of long-term care to feel at home, they must be able to successfully engage in place-making, to create and negotiate an intimate relationship with the new setting in which they live (Chaudbury et al,

2013, p.110; Wagner, 2022, pp.1-2).

There are three primary factors contributing to creating a home-like environment, or the place-making process, for long-term care residents. First, there are physical design elements, such as private rooms, particularly those that limit distractions or triggers for residents, as well as elements that facilitate the continuation of daily routines familiar from before relocation to long-term care (Chaudhury et al, 2017, pp.95-96; Davies, 2018; Day et al, 2000, pp.407-408; Hutchings et al, 2011; Leibrock, 2000; Olsen and Albensi, 2021; Wada et al, 2019). Second, there are the elements of care, such as the provision of opportunities for meaningful activities, autonomy, and the encouragement of sociability among residents (Chaudbury et al, 2017; Førsund et al, 2018, pp.2-23; Hutchings et al, 2011; Moore, 1999, pp.141-143; Ryman et al, 2019; Thorson and Davis, 2000, pp.133; Wada et al, 2019; Will, 2020). Third, personal objects, namely photos and wardrobe items such as clothing and accessories, play a large role in residents experiencing home-like environments in a long-term care setting (Board and McCormack, 2018, p.3070; Buse et al, 2018a; Buse et al, 2018b; Lee and Bartlett, 2021; Miller, 2008)

2.1.1 Physical Design Elements

Private rooms, particularly those that also include private bathrooms, are essential for successful place-making by residents in long-term care settings. Hutchings et al. (2011) explain that family members of long-term care residents interviewed said that private rooms were critical in enhancing contentment and quality of life, thereby contributing to an overall sense of residents being “at home” (pp.224 and 228). Wada et al. (2019) expand on this, describing how a sense of ownership over the physical environment, as is enabled by private rather than shared rooms, manifests through residents adorning the space with their personal belongings, distinguishing the

space from a purely institutional environment, which contributes to a sense of being at home (p.1269). This further supports the previously mentioned argument by Rowles et al. (2013), that the presence of personal objects is essential in the process of place-making upon relocation (p.116).

Other physical design elements that limit distractions or triggers for residents may also serve an important role in facilitating place-making by residents in long-term care facilities. Reducing distractions likely contributes to a sense of home for residents because it allows them to feel a level of familiarity with and control over the physical environment in which they live, which are key elements of feeling "at home" (Wada et al., 2019, p.1269). Wada et al. (2019) further suggest that cleanliness, low ceiling height, lighting, colour of walls and floors, and hidden institutional structures, like the nursing desk, are design features that increase home-like feel by reducing distraction (pp.1268-1269).

As suggested by Rowles et al. (2013), the final physical design element essential to place-making according to residents in long-term care is a structural layout allowing them to continue in the daily routines that have become familiar to them over their lifetimes (p. 116). Hutchings et al. (2011) discuss how small care facilities with cottage-like structures that include open kitchens and laundry rooms allow residents to participate in familiar household activities, such as baking and folding clothes (p. 228). Access to an office-like space with amenities such as a computer or typewriter and a phone is also recognized by Leibrock (2000) as important, as it allows residents who had spent their entire careers in an office environment to orient their days around a familiar routine or environment (pp.34). The importance of physical design elements supporting routines based around careers is further supported by Davies (2018), who notes the recurring distress of a resident whose life had previously been largely shaped around their schedule as a government

employee, but upon relocating to a long-term care facility, had no structure or purpose to their daily routine (p. 43). Likewise, Olsen and Albensi (2021) identify residents having open access to spaces such as a hair salon or theater as a physical design element that allows a sense of being "at home" in a community sense and reduces stress (p.435).

2.1.2. Elements of Care

Another way to facilitate place-making and a sense of home for long-term care residents is via elements of care. These elements of care include the support of resident autonomy, the encouragement of sociability among residents, and the provision of opportunity for meaningful activities. Following Rowles et al. (2013), these elements of care should enable residents to recreate and renegotiate the intimate relationships they have with the place they live and those that they interact with there.

In the literature reviewed for this thesis, support of resident autonomy was the element of care most often linked to creating home-like environment. Wada et al. (2019) state that support of resident autonomy, through the provision of choice and control over things such as care, activities, meals, and the physical environment, empowers residents to successfully place-make and contribute to a sense of home. Additionally, residents who autonomously make the decision to move into long-term care are more likely to feel at home in the facilities (pp. 1269). The impact of residents autonomously choosing to enter long-term care, and in particular the facility to which they relocate, is further emphasized by Hutchings et al. (2011). They explain that when residents are consulted about moving into long term care, both they and their families report a more positive experience overall and a greater sense of being at home (pp. 225-227),

demonstrating the importance of both autonomy and social supports in contributing to a sense of home following relocation.

Further, Dew et al. (2013) discuss how some degree of autonomy in the prescription and receipt of medication can support a sense of home-likeness in long-term care settings. They explain that many people in long-term care have managed their medication in our own homes throughout their lives, and come to view medications as consumer goods that are personalized and reconfigured at home, like other household items (p.29). They are familiar with household medications as a treatment that is not just passively received but rather actively tactically engaged with (pp.29-30). This may be an example of an intimate relationship as such relationships are understood by Rowles et al. (2013), in that it has both lay and subjective meanings for the individual taking the medication (p.255). If these subjective meanings were to include perhaps recognizing self-administration of medication in one's own home as an exercise of control and autonomy, then, according to Rowles et al. (2013), this meaning would have to be renegotiated upon relocation to long-term care (p.166). Therefore, continuation of familiar medication practices with associated subjective meanings could support a sense of home for long-term care residents (Rowles et al., 2013, p.116).

A second element of care essential for place-making is sociability. Wada et al (2019) describe interpersonal relationships as critical to creating a sense of home in long-term care settings, which when social connections are fostered, can be place that allow for individuals to gather together and develop a sense of belonging and community (p.1270). In particular, environments designed to allow residents to continue engaging in routines that reflect familiar socio-cultural rules will contribute to a sense of home (pp.1270-1271). This further reflects what has already been discussed about the benefits of physical design elements that enable familiar

routines to be followed, although in this section interpersonal and social elements will discussed rather than structural ones.

Will (2020) identifies the impact that the COVID-19 pandemic has had on sociability of residents in long-term care, as residents and their families have experienced distress as a result of visitor and socialization restrictions in the interest of infection prevention and control (p.969). The effects of this, Will (2020) predicts, will be visible in future studies on the sociology of health and illness (p.969-970).

Beyond the sociability that results from interactions between residents and their families, however, Hutchings et al. (2011), Chaudbury et al. (2017) and Leibrock (2000) list a number of relationships that occur within long-term care facilities that allow for the creation of a sense of home. Hutchings et al. (2011) demonstrate that the relationships between residents and staff are equally as important as those between residents and their family members. They state that caring and compassionate staff greatly contribute to a home-like atmosphere through their everyday interactions with the residents (p.228). Chaudbury et al. (2017) show that the relationships between residents can contribute greatly to a sense of home, particularly at mealtimes (p.95-97). Leibrock (2000) illustrates the role that the unconditional love of a pet can play in the sociability of residents, as they attempt to create a sense of home in long-term care environments (p.40). Clearly, therefore, even when sociability between residents and their families is limited, there is ample opportunity to support the fostering of social relationships within care facilities.

The final element of care that is essential to creating a sense of home for residents in long-term care is the opportunity for engagement in meaningful activities. Leibrock (2000) explains that engagement in meaningful activities such as gardening or participating in the keeping of their own environment through food or laundry preparation is essential for residents

to expend excess energy, continue in familiarized routines, and feel at home in long-term care facilities (pp.40-41). Hutchings et al. (2011) similarly report that gardening and folding laundry are meaningful activities that create a sense of home for residents, but also further suggest that new activities such as scrapbooking or sharing old memories with others through pictures can help with sociability and forming new relationships (p.228). The use of meaningful activities to encourage relationship-building was supported by Wada et al. (2019), who argue that doing so will help recreate a sense of home (p.1271). Meaningful activities are not only beneficial as elements of care in their own right therefore, but also create opportunity for familiar routines and socialization, which, as already noted, are important for place-making and creating a home-like environment.

2.1.3. Personal Objects

The third factor that plays an important role in residents successfully place-making in long-term care settings is the presence of personal objects. There is a growing focus on the role of objects in the sociology of health, referred to as the study of materialities of care (Buse et al, 2018a, p.713-714; Buse et al, 2018b, p.243). Buse et al. (2018b) explain that study of the materialities of care examines the relationship between object, or materialities, and practice. According to these studies, practice is ongoing and dynamic, involving routine activity and embodied knowledge (p.249). The study of materialities of care therefore seems similar to the study of place-making, as it involves recognition and understanding of the ongoing construction and negotiation of relationships (Rowles et al., 2013, p.110). Further, as will be noted in the following sections, the discussions on materialities of care reveal how personal objects help to

facilitate some of the previously mentioned factors essential in the place-making process, particularly autonomy, familiar routines, and meaningful activities.

To begin, the mere presence of personal objects, even those that are not particularly important or sentimental such as hair curlers or teacups, appears to facilitate place-making for residents in long-term care. Lee and Bartlett (2021) argue that the selection process by which residents choose what personal items to take with them when relocating to long-term care is important in supporting resident autonomy, as they are often left out of the decision (p.1480). Further, they explain that having access to the exact objects used in daily routines prior to relocation to long-term care can facilitate the continuation of such routines for residents in care settings, serving as memory cues (pp.1480-1481).

Buse et al. (2018b) build on the importance of using personal objects in daily routines, noting that for many residents, there may have been a routine of receiving care in their own homes prior to entering long-term care. The example given is a woman who had her blood-pressure taken daily while enjoying a cup of tea in her kitchen (p.247). In this situation, care was already integrated into the woman's daily routine, and therefore the reconstruction and renegotiation of her routine in long-term care could be facilitated through the presence of familiar objects such as her teacup. The routine and objects used would therefore be familiar, despite the new setting.

Utilization of familiar routine may also facilitate further clinical elements such as the giving of medication, which, once an individual has been transferred to a long-term care setting, often becomes the responsibility of careworkers when it previously would have been taken autonomously by the individual. Therefore, by working medication distribution into a routine

that is familiar from prior to the long-term care admission, the resident can maintain some sense of routine and autonomy from a process that has become suddenly clincialized.

Clothing has also been identified within the literature as critical to maintaining the dignity of personal identity for residents of long-term care. The clothing worn, as well as the condition and appearance of clothing when it is worn, serves both the wellbeing and health of residents (Armstrong & Day, 2017, pp.1-7). It is further argued that autonomy over clothing helps contribute to a sense of home in long-term care by subverting the loss of personaly identity and subjugation to control that can be experienced with admission to total institutions such as long-term facilities (Artner, 2018, pp.1-2).

Miller (2008) discusses another way in which the mere presence of personal objects can influence place-making by residents, by explaining the role that personal objects play in how others perceive and interact with us. Presenting an analysis of a man who had virtually no personal objects in his home, explaining how the lack of personal objects made Miller question the man's personhood and integrity, Miller (2008) further notes how the complete lack of personal items led him to question to man's wellbeing, his sanity (pp.8-17). As previously mentioned, sociability is a key element of care for the successful place-making of long-term care residents. Clearly, however, a lack of personal objects may impact the sociability of individuals such as residents in long-term care, impacting how others such as visitors, other residents, or careworkers interact with them.

2.2 HOME AND HEALTH

Feelings of being at home in long-term care settings can optimize wellness, quality of life, and healing for residents, a key insight in the field of environmental gerontology (Collier et

al., 2015, p. 698-700; Molony; 2010; p.291; Robinson et al., 2010; Wahl & Weisman, 2003, pp.620-621). There is a high prevalence of diseases and disorders among long-term care residents, including dementia, depressive disorder, Parkinson disease, or infections (Rotolo 2020; American Parkinson Disease Association, 2018; Anderson, 2004; Seitz et al, 2010). These diseases and disorders can also cause behavioural symptoms, most commonly apathy, anxiety, agitation, and aggression (Olsen and Albensi, 202, p.427). Seitz et al. (2010) conclude that these behavioural symptoms were the most common psychiatric disorders in long-term care facilitates (p.1034), and, therefore, the presence of these symptoms is a significant impact on the health and wellbeing of residents.

The literature review suggests that there are three ways in which creating a sense of home in long-term care can help improve the health outcomes of residents: (1) directly improving the health of residents through reduction of behavioural symptoms of common diseases and disorders in long-term care (Davies, 2018, p.86, Jessop et al, 2017, p.1392; Leibrock, 2000, pp.32-34; Chaudbury et al, 2017, pp.95-97; Kontos, 2011, pp.329-330), (2) reducing reliance and overuse of anti-psychotic drugs and avoiding the associated negative side effects (Davies, 2018, p.86, Jessop et al, 2017, pp.1391-1392; Olsen and Albensi, 2021, p.427), and (3) mitigating the negative health impacts of relocation to long-term care (Hutchings et al, 2011,p.225; Ryman et al, 2019, p.675; Thorson and Davis, 2000, p.113). Beyond these factors, however, it is also important to note an element that opposes homelikeness and threatens resident health, which is the risk of clinicalization of care (Cowling, 2000; Cowling & Taliaferro, 2004).

2.2.1. Mitigating the negative health impacts of relocation to long-term care

Overall, the literature reviewed suggests that while relocation can result in higher rates of mortality and morbidity, the impact can be mitigated. This mitigation may occur by encouraging autonomy, through involving the individual in the decision-making process as much as possible, ensuring the long-term care facility can offer meaningful activities and engagement for the resident once the relocation has occurred, and by creating a physical environment in the individual's new living environment that creates a sense of familiarity, safety, and security.

The literature highlights that rates of mortality and morbidity among persons with dementia and other diseases increase upon relocation to long-term care. According to Hutchings et al. (2011), relocation to or within a long-term care facility can result in adverse health effects, including an increased risk of mortality or morbidities such as fall, stress, depression, or insomnia (p.225). Ryman et al. (2019) argue that the relocation of a person can be traumatic, or cause what they call "relocation stress," which can cause adverse physical and mental health effects (p.675). Thorson and Davis (2000) use a similar term, transfer trauma, to refer to the negative health effects associated with relocation, particularly the increased rate of mortality (p.113). According to these authors, the increased risk of mortality and morbidity upon relocation to long-term care can also be mitigated by action on the part of caregivers or administrators.

The first potential method by which those involved in the delivery of care can lessen the risk of mortality and morbidity for individuals upon their relocation to long-term care is to encourage individual autonomy before, during, and after the relocation. Førsund et al. (2018) highlight that many persons view living in their own home as essential to their autonomy, and associate long-term care with a loss of freedom and choice. When residents in care were

involved in shaping their own services, however, the perception shifted to one of being informed and in control (p.21-22). They further suggest that by allowing an individual to be involved in such a way and to maintain as much of their autonomy as possible, they will be better able to reconstruct their sense of lived space, understood in this article as a feeling of being home (p.2&23). As noted by Molony (2010), a sense of being home can optimize wellness, quality of life, and healing for individuals in care (p.291). Ryman et al. (2019) state that when individuals are more involved in the decision-making processes surrounding the relocation, their quality-of-life increases, and the stress resulting from the relocation is lessened. Thorson and Davis (2000) explain that lack of personal control, in particular, is a predictor of higher rates of mortality upon relocation (p.133).

Another potential method for caregivers or administrators to reduce the negative health impacts associated with relocation of individuals to long-term care could be ensuring that meaningful activities and opportunities for meaningful engagement exist in the care facility. Hutchings et al. (2011) conclude that offering meaningful activities such as recreational therapy and social clubs in long-term care can greatly improve the quality of life of residents, even those who have recently been relocated (p. 228). Førsund et al. (2018) similarly show that while some people viewed relocation to long-term care as resulting in boredom, it is possible for facilities to be a place where social networks and relationships can be built and fostered. Residents who engaged in meaningful activities such as socializing, cleaning their space, or being physically active reported having a great degree of contentment and more energy (p.21).

The risk of mortality and morbidity associated with relocation of individuals to long-term care, particularly those with dementia and other diseases or disorders causing behavioral symptoms, may be decreased through ensuring the presence of certain physical elements in long-

term care facilities. For example, Huijbers et al. (2011) conclude that persons with dementia and other cognitive disorders may have a spatial memory bias for positive emotions, which would indicate that by equipping spaces in long-term care facilities with items with which residents have a positive association, the process of regaining a sense of home could be made easier (p.7). Likewise, the ability to ensure a safe and secure environment is noted by Førsund et al. (2018), who report that many long-term care residents reflect on the care environment as a place of hospitality and relaxation.

In conclusion, therefore, while it is widely recognized that relocation of individuals to long-term care can result in increased rates of mortality and morbidity, steps can be taken to lessen the impact. By involving the individual being moved into long-term care in the decision-making process surrounding the relocation, providing the opportunity for meaningful activities in the care facility, and equipping the physical environment with particular items and safety features, the process of transition and regaining a sense of home can be made easier. As a result, the risk associated with mortality and morbidity upon relocation to long-term care can be reduced, and quality of life improved.

2.2.2. Improving health through reduction of behavioural symptoms from diseases/disorders common in long-term care residents

Olsen and Albensi (2021) illustrate private rooms and the increased presence of home-like décor associated with them help to reduce what is referred to as the four "A's": apathy, anxiety, agitation, and aggression (p.427) (Jessop et al, 2017, pp.1391-1392). These are often behavioural symptoms of dementia, but also occur with other diseases or disorders common among long-term care residents, such as depression, Parkinson disease, or even mild to moderate

infections (Aging Care, 2021; American Parkinson Disease Association, 2018; Anderson, 2004). As these behavioural symptoms are often associated with resident wandering, private rooms may also improve infection prevention and control efforts by eliminating the requirement of residents to share a small physical space, and by helping to prevent the spread of infection through residents unnecessarily wandering into the rooms of others, which was noted as an early contributing factor in the spread of COVID-19 through long-term care facilities (Jessop et al, 2017, pp.1392; Olsen and Albensi, 2021, pp.430-432).

Further, the literature provides examples of how physical design elements that reduce distractions for residents in long-term care facilities can positively impact health, as distractions often serve as a trigger for behavioural symptoms (Davies, 2018, p.86). Reducing distractions can also improve the health of residents in long-term care through the prevention of falls as a result of residents startling at sudden noises. Design elements such as quietly closing doors and the elimination of loud doorbells help residents to maintain a sense of control and comfort associated with home and prevent the health risks associated with the sudden impact of a fall (Leibrock, 2000, pp.32-34).

Looking now at ways in which elements of care may directly improve the health of long-term care residents, both Kontos (2011) and Olson and Albensi (2021) discuss the role that sociability plays in the health of residents in long-term care. Kontos (2011) states that limited sociability is often associated with bodily impairments such as cognitive decline, issues with hearing, speech and sight, and reduced ambulation (pp.329-330). Olson and Albensi (2021) go into slightly more detail, naming increased risk of cardiovascular disease, obesity, stroke, anxiety, depression, interrupted sleep patterns and cognitive decline as risk of social isolation that lead to further health issues. Olson and Albensi (2021) also highlight the particular irony of

the risk of lack of sociability as a result of COVID-19 infection prevention measures, which is that social isolation is associated with increased susceptibility to infection agents such as coronavirus (p.431).

Leibrock (2000) and Hutchings et al. (2011) discuss the ways in which engaging in meaningful activities can improve the health of residents. Leibrock (2000) describes how meaningful activities such as gardening and, as already noted, folding laundry provide exercise for residents in a gentle way, encourage them to be outside enjoying fresh air or to socialize in an environment such as the laundry room, and help them to maintain the physical skills and dexterity necessary to complete such tasks (p.40). Hutchings et al. (2011) further note that meaningful activities that reflect familiar routines and those that encourage reflection help improve the memory and stabilize the cognitive function of residents with dementia and other progressive diseases (p.228).

Leibrock (2000) argues that supporting autonomy and decision making for residents in long-term care can improve their health in two ways. First, she indicates, supporting autonomy can reduce frustration and confrontation that often results in residents experiencing behavioural symptoms (pp.37-38). Second, encouraging autonomy and independence for residents with progressive diseases can actually help to preserve their skills, slowing the cognitive decline associated with the disease (pp. 32 and 41).

In addition to establishing that the mere presence of personal objects, regardless of what they are, may facilitate creating of a sense of home and improving the health of residents in long-term care, the resources for this area essay suggest that two types of objects may be of particular importance: photos and clothing/accessories. Miller (2008) and Hutchings et al. (2011) explain the role of photos in fostering sociability and engagement in meaningful activities, elements of

care already established as being essential in creating a home-like environment for residents. Miller (2008) details how photos help to sustain personal relationships with people, places, or things we are not often around, explaining that such objects are conduits to a wider knowledge of their subjects, allowing the relationship to continue in some manner (pp.27 and 58). Sociability is therefore supported by the presences of photos, not just the traditional sense of social relationships between individuals but also in sustaining relationships between an individual (the resident) and the outside world and its inhabitants in general. Similarly, Hutchings et al. (2011) describe the role that photos can play in meaningful activities such as recreating a familiar garden, making a memory book, or recounting stories about the subject of the photo to others (p.228).

The potential health impacts of residents having access to photos, therefore, should relate to those associated with the elements of care that photos support, specifically sociability and engagement in meaningful activities. Kontos (2011) and Olson and Albensi (2021) discuss how socialization is associated with lower rates of cognitive decline, cardiovascular disease, issues with hearing, speech and sight, and mental health concerns (pp.329-330; p.431). Hutchings et al. (2011) demonstrate that meaningful activities that reflect familiar routines and those that encourage reflection help improve the memory and stabilize the cognitive function of residents (p.228). Therefore, the presence of photos can serve as a helpful tool in not only facilitating the place-making of residents in long-term care, but also in improving their health.

Like photos, clothing and accessories appear to support a sense of home by facilitating a necessary element of care, namely autonomy. Buse et al. (2018a) argue that resident autonomy over the clothing and accessories they own and wear is essential for quality of life and a sense of home-likeness (pp.714 and 719). This, they suggest, is because of the extent to which our society

associates particular items with the idea of home, such as wearing comfortable but perhaps aesthetically unappealing clothing (p.719). Miller (2008) further supports the idea of autonomy over clothing being essential to feeling at home even outside of long-term care settings, recounting his interview with a woman who was deeply uneased by having to wear maternity clothes while pregnant and immediately post-partum (p.150). Lee and Bartlett (2021) discuss the role of accessories in supporting place-making for residents in care, explaining that autonomy in packing and carrying a handbag or purse contributes to a sense of identity and allow the resident to maintain and cultivate a sense of home (p.1473).

Therefore, as is the case with photos, the health effects of residents having and wearing their own clothing and accessories are related to those associated with the elements of care supported, specifically autonomy. As Leibrock (2000) explains that encouraging autonomy and independence for residents can actually help to preserve their skills, slowing the cognitive decline associated with common disorders and disease in LTC settings (pp. 32 and 41).

2.2.3. Reducing reliance and overuse of anti-psychotic drugs

The physical design elements, elements of care, and personal objects that reduce the behavioural symptoms of commonly occurring diseases and disorders in long-term care further serve to improve resident health by reducing reliance and overuse of anti-psychotic drugs. Anti-psychotic medications can have serious side-effects for residents in long-term care. A 2023 report by Trenaman et al. focused on Nova Scotia in particular reveals the extent of the issue for the province, explaining the 90% of beneficiaries of the Nova Scotia Seniors Pharmacare Program who were dispensed antipsychotic medications between 2009-2017 were living in long-term care at the time (pp.186-187). It was further noted that of those receiving antipsychotic

drugs in long-term care, over 80% continued to receive the medication after surviving a fall related hospitalization, a common side effect of the antipsychotics (pp.187-188).

The BC Patient Safety & Quality Council (2015) also notes that in comparison to non-pharmacological interventions, antipsychotic medications are associated with higher rates of strokes and falls and can lead to such a sedated state that the individual's personality is essentially erased (p.2-3). Furthermore, the Canadian Institute for Health Information (2021b) the Alzheimer's Society (2021), and the Social Care Institute for Excellence (2020) state that, particularly for persons with other health issues, antipsychotic use can have the side-effect of extreme sedation, sudden drops in blood pressure, fall and strokes, fractures, or even death. Hagen et al. (2005) explain that because of those side-effects already mentioned, in addition to orthostatic hypotension, anticholinergic effects, cardiac complications, weight gain, metabolic complication, and cognitive decline, concerns around the widespread use of antipsychotics in long-term care have existed for decades.

For the United States, this concern has resulted in legislated standards for the use of psychotropic drugs in care facilities, but Canada has no such regulations (p.180). Health Quality Ontario (2015) emphasizes the impact that increased sedation and risk of falls in particular can have on the quality of life of long-term care residents (p.5). Machado-Duque et al. (2021) further argue that individuals who use antipsychotic drugs frequently present with anticholinergic side effects, including hypotension, confusion, drowsiness, cognitive impairment, and severe extrapyramidal symptoms (unintentional movement) that can be fatal (p.2). Therefore, the use of such medications can carry serious side effects, and should be prescribed with caution, particularly for those in long-term care.

As mentioned, Hagen et al. (2005) and Walker et al. (2020) state that while the United States has legislated standards regarding the use of psychotropic drugs in care facilities, Canada has no corresponding regulations (p.180). The study suggests that, as a result of this lack of standards, Canada has some of the highest rates of antipsychotic use in long-term care facilities in the developed world, with a use rate of around 30-33% (p.188). The Canadian Institute for Health Information (2021b) reported an even higher percentage, stating that at that time, 39% of seniors in long-term care were prescribed at least one antipsychotic medication. The report further notes that improper use is indicated, as 23% of residents of long-term care with no symptoms of psychosis were receiving antipsychotic medications, contrary to treatment guidelines. The University of Calgary (2014) makes a very similar suggestion, specifically that anti-psychotic medication is over-utilized in Alberta long-term care facilities, being given to 28% of residents with no indication of agitation, aggression, or psychosis (p.12).

The BC Patient Safety & Quality Council (2015) and Health Quality Ontario (2015) offer some reasoning as to why the overuse of antipsychotic medication is so prevalent in long-term care in Canada. Firstly, the BC Patient Safety & Quality Council (2015) argues that seniors in long-term care facilities are extremely vulnerable to receiving inappropriate medications such as anti-psychotics when facilities lack alternative approaches to managing difficult behaviors (p.2-3). Health Quality Ontario (2015) explains that the difficulty in applying alternative approaches to behavior management can result from facilities experiencing a lack of staff, improper or lack of training, or a lack of financial resources (p.13). According to the Canadian Institute for Health Information (2022), the use of antipsychotic drugs for residents of long-term care had been improving prior to 2020, with rates dropping by 26% between 2014-2020 (pp.43-44).

Unfortunately, the same study also shows that since the onset of the COVID-19 pandemic, antipsychotic use rates have increased in long-term care in several provinces, including Ontario, Alberta, and British Columbia (p.48). While the literature does not offer possible ways to overcome the issues that may prevent some facilities from adopting alternative approaches to behavior management, the articles do detail what non-pharmacological methods could look like.

The BC Patient Safety & Quality Council (2015) reports on methods used to reduce the use of antipsychotic medications in several long-term care facilities in British Columbia. These methods included increasing meaningful activities such as planting vegetable gardens, developing new recreations programs to allow for social connection within the facility, using aromatherapy to create a comfortable environment through the use of familiar scents, allowing residents to help plan and prepare their own meals, and modifying the living environment to promote comfort and familiarity, reflecting the importance of physical design elements such as private rooms and elements of care like meaningful activities (p.11-15). The Canadian Institute for Health Information (2022) also emphasizes the effectiveness of social connectedness and the opportunity for meaningful activity as non-pharmacological behavioral interventions (p.43). These methods reflect the idea that creating a sense of home for residents in long-term care can improve their wellbeing and health outcomes, as suggested by Molony (2010) and noted in previous synopses for this course (p.292).

Further, the specific factors that contribute to a sense of home for long-term care residents include such things as meaningful activities like gardening and cooking, forming social connections, and familiar environments (Bigonnesse et al., 2014, p. 64-365 and 368-370; Board and McCormak, 2018, p.3073-3077; Hutchings et al. 2011, p.368-370). More specifically,

therefore, the factors that contribute to creating a sense of home for residents in long-term care may also offer a non-pharmacological alternative to the use of antipsychotic medications, thereby avoid the serious risks associated with the drugs.

2.3 "HOME" PRIOR TO THE COVID-19 PANDEMIC

Creating home-like environments in Nova Scotian long-term care facilities was required through numerous standards set in the *Long-Term Care Program Requirements* (2019) which, as already stated, gave the vision for continuing care in Nova Scotia as residents living well in a place they can call home (p.5). The individual standards and related outcomes were applied to all long-term care facilities in the province and reflect clearly the elements of care set out previously in this literature review. Reviewing these standards will therefore offer a representation of how home was experienced in long-term care in Nova Scotia prior to the implementation of COVID-19 restrictions which, when in place, superseded the *Long-Term Care Program Requirements* (2019).

In addition to being set out in the vision for continuing care, a overarching goal of establishing a sense of home in long-term care is also articulated in standard 3(8) of the program requirements, which states that creating a homelike environment for residents and their families is a general principle guiding the requirements (p.6). 'Homelike', as it is used within the program requirements document, is defined as "a warm and inviting space which residents and/or family members are encouraged to personalize" (p.9). It should also be noted the facilities within the document are themselves referred to as 'homes', reflecting efforts of creating a homelike environment even in the language used by legislators and administrations (p.9).

Referring to all elements of care, standard 6.4(1) of the program requirements necessitates that all care be resident-centered, in that it must be delivered in a manner that recognizes the importance of providing a homelike environment that emphasizes meeting the 'physical, health, cultural, social, mental and emotional needs of all residents' (p.18). Standard 12.1 speaks to the role of physical space and environmental services in creating a sense of home, stating that the wellbeing of residents should be enhanced through the facilities homelike physical environment (p.44). The standards and definitions set out the program requirements, therefore, reflect the role and required the utilization of physical environments, non-physical elements of care, and personal objects in creating and maintaining a sense of home in long-term care, prior to the COVID-19 pandemic.

2.4 CONCLUSION OF LITERATURE REVIEW

The purpose of this literature review has been to synthesize the available literatures on how a sense of home is experienced in long-term care, how a sense of home relates to resident health and wellbeing, and how the COVID-19 pandemic impacted long-term care residents. This synthesis has occurred through analysis of peer-reviewed literature and supplemental media reports to frame long-term care experiences in the context of the pandemic in Nova Scotia.

A number of themes emerged from the literature; these themes speak to the how a sense of home is experienced in long-term care and how it relates to the health and wellbeing of residents, both in broader settings and during the COVID-19 pandemic. They include those around physical design, elements or methods of care delivery, the role of personal objects in homelike environments, ways to improve symptoms of common disorders among residents and limit the side-effects of drugs used to treat such symptoms, and mitigation of the negative

impacts of relocation to long-term care. As will be discussed in the proceeding methods section of this research, these themes as they emerged in the literature review also served as the codeset with which the theoretical sampling in this research project was performed.

CHAPTER 3 METHODS

The goal of this project is to contribute to an understanding of the likely impacts of the COVID-19 related restrictions in long-term care on residents' health and wellbeing by asking two research questions. First, what factors contribute to a sense of home for residents in long-term care and how do these factors impact residents' health and wellbeing and second, what restrictions were imposed in LTC facilities in response to the pandemic, and how were these restrictions likely to impact residents' feelings of being at home? In order to answer these questions, I performed a detailed content analysis based in theoretical sampling of (1) peer-reviewed literature on the impact of homelike environments on resident outcomes, (2) public statements and reports in the media on this issue and (3) in-depth, narrative reports of resident lives in long-term care published by social science and nursing professionals working in the field, and (4) COVID-19 Management in Long-Term Care Facilities Directives released by the Nova Scotia Department of Health and Wellness (Bernard et al., 2017).

This project employed a few different methods to address my research aims of understanding the likely impacts of the COVID-19 related restrictions in long-term care on residents' health and wellbeing. The literature review synthesized the peer-reviewed literature on the concept of a sense of home and the impact of homelike environments on resident outcomes, supplemented by local public statements and reports in the media to contextualize the information in the Nova Scotian long-term care field. Reviewing and synthesizing this literature also formed the basis of my methodological approach for this project: theoretical sampling as a form of grounded theory. This allows the information garnered through the literature review of peer-reviewed texts to be applied to a more in-depth narrative on the lives of long-term care

residents, in order to test how the factors identified as relevant through research may emerge in alternative forms of data presentation.

Altheide (1996, pp.9-11) recommends theoretical sampling as a way for a researcher to inspect and reflect on a wide variety of initial materials in order to identify what types should be included in the study, bearing in mind practical considerations such as time, access, and availability. According to Bernard et al. (2017), theoretical sampling often occurs as a sub-category of grounded theory in order to allow researchers to make informed decisions about what data to collect, code, analyze, and interpret that would not have been permitted within representative sampling (Haig, 2010, pp.77-78). Grounded theory, Bernard et al. (2017) and Haig (2010, pp.77) state, is a set of systemic techniques for inductively examining case studies, plus the application of deductive reasoning in order to construct theories from the resulting data. Grounded theory is undertaken through three steps: (1) identifying themes within texts and coding the themes for those texts, (2) connecting the themes in theoretical models, and (3) displaying the validity of those models. Within grounded theory, theoretical sampling occurs occurs after a set of texts has been analyzed and the development of a theory to answer the research question has begun in light of that analysis (Bernard et al., 2017, pp.465-466; Charmaz and Belgrave, 2019; Chun Tie et al, 2019, pp.2-4).

Utilizing these methods of qualitative content analysis and theoretical sampling can successfully deliver a socially revealing sample of knowledges, data, or information because it allows for a relatively wide range of data while still allowing for the practical considerations of time, access, and availability (Altheide, 1996, p.9). The development and testing of codesets and matrices further allows for persuasive or robust findings that can evolve as research is conducted in order to build from one question to the next and give refined meanings to

collected data (Altheide, 1996, p.4; Bernard et al, 2017, pp.459-464). In contrast to other forms of knowledge synthesis, grounded theory, including theoretical sampling, is recommended for developing broadly-applicable theory from detailed, situation specific and substantial studies or theories (Barnett-Page and Thomas, 2009; Kearney, 1998, p.179). This, it is suggested, makes grounded theory and theoretical sampling particularly valuable for research in care settings (Barnett-Page and Thomas, 2009; Kearney, 1998, p.180). It is for these reasons that the methods of qualitative content analysis and theoretical sampling were selected for this research.

Therefore, with the series of peer-reviewed articles and supplemental media reports having been analyzed during the completion of my literature review, I was also able to use these texts to develop a set of codes (Appendix A) to guide the theoretical sampling that I then conducted (Bernard et al., 2017, pp.465-466; Charmaz and Belgrave, 2019; Chun Tie et al, 2019, pp.2-4). These codes represent factors that, based on the texts synthesized within my literature review, I theorized to be significant in creating a sense of home and relating to the health and wellbeing of residents in long-term care. These factors, which became my codes, were those that appeared most frequently in the literature while also being accompanied by contextualized information detailing the relationship of the factors to the health and wellbeing of individuals in care environments.

Codes developed through grounded theory, including theoretical sampling, each represent a distinct idea (Martin & Turner, 1982, p.149). For the codesets in my research, I decided to employ the use of primary, secondary, and tertiary codes to capture each factor contributing to a sense of home and how those factors impact resident health and wellbeing. Each primary code acts as an umbrella under which the secondary, and subsequently the tertiary, codes fall. Therefore, tertiary codes will act as precise examples of secondary codes, which further serve as

categories of primary codes. These primary, secondary, and tertiary codes will all have been discussed in the literature review, however, each of the codes in Appendix A is also accompanied by a definition for the purposes of clarity. The definition was developed to ensure that the incidence recorded for these codes align with the questions being asked and present a set of data that can be analyzed for the purpose of my research.

Following the development of these codes and the theory of how they would contribute to a sense of home and resident health and wellbeing, I then conducted a mixed-method qualitative and quantitative analysis of the presence of the codes in a sample of four narrative reports of resident lives published by social science and nursing professionals working in the field of long-term care. These narrative reports were relied on in place of conducting interview with residents due to ongoing restrictions preventing non-essential visitors to long-term care facilities at the time when the research was conducted. The reports do, however, offer the detailed, situation specific substantial studies or theories advocated for by Barnett-Page and Thomas (2009) and Kearney (1998, p.179) when conducting studies in nursing or the medical social sciences. The sample set was limited to four extensive narratives comprised of multiple shorter case studies on individual residents based on Bernard et al's (2017) suggestion of minimum of six samples for case studies (p.158).

While the texts comprising the literature review, and from which the codeset was developed, were peer-reviewed articles, the narrative style reports against which the codeset was tested are books which offer more in-depth analyses of the lived experiences of residents in long-term care. Therefore, while the literature review and codeset demonstrate the results of methodological studies, the narrative reports against which the codes were tested detail less structured, more organic findings of the lives of residents.

Having then tested my codeset and theoretical models, I was able to identify factors contributing to a sense of home for residents in long-term care environments, and how that sense of home impacts the health and wellbeing of long-term care residents. Then, through reviewing the Nova Scotia *COVID-19 Long-Term Care Facility Management Directives*, I was able to summarize the likely impact of these restrictions on the health and wellbeing of residents. These directives were the comprehensive and exclusive authority document on COVID-19 policies in long-term care in Nova Scotia. Therefore, they offer a complete overview of the policies to which residents were subject.

The possible limitations of my methods relate primarily to my first research question, which factors contribute to a sense of home for residents in long-term care and how do these factors impact residents' health and wellbeing, because answering this question requires relying on the findings of preexisting case studies. These narratives and studies, who they were conducted on, who they were performed by, and the presentation of their findings will all have been influenced by factors such as political and funding guidelines, the researchers' own assumptions or implicit biases, and the representativeness of the studied group or case (Altheide, 1996, pp.4-6; Bernard et al, 2017, pp.117-119). Thus, any limitations in these case studies will carry into my research.

In order to properly address and mitigate the limitations associated with relying on third-party data, I utilized Public Health Ontario's (2015) meta-tool for quality appraisal of public health evidence to assess each of the narrative reports relied on for this research. I opted to use this particular quality appraisal tool because it was developed to be broadly applicable to a diverse range of public health topics and study designs and to maximize transparency and assessment (pp.1-2). The framework follows a four-part structure of relevance, reliability,

validity, and applicability. Each of the narrative reports relied on for this research were deemed by the tool to be high quality and the details of the assessments are located in Appendix B.

To conclude this methods section, therefore, the methodology for this project was developed with the aim of contributing to an understanding of the likely impacts of the COVID-19 related restrictions in long-term care on residents' health and wellbeing while working within the limited timeframes and data collection processes available. By engaging in theoretical sampling of peer-reviewed articles to develop a codeset from the literature review, I was able to efficiently develop informed theories on the on a sense of home is created in long-term care and the subsequent relationship between the environment and the health and wellbeing of residents.

These theories were then tested against in-depth, narrative reports of resident lives in long-term care published by social science and nursing professionals, in lieu of interviewing residents, which was not possible given the long-term care restrictions in place at the time of the research being conducted. Finally, having tested the codeset and accompanying theories against the narrative reports and conducting an analysis of the resulting qualitative and qualitative data, I applied the revised theoretical model of how a sense of home is created in long-term care to the COVID-19 restrictions placed on residents during the pandemic, in order to contribute to the understanding of the impact of these restrictions on resident health and wellbeing.

CHAPTER 4 CREATING A SENSE OF HOME AND THE LINK BETWEEN HOME AND HEALTH

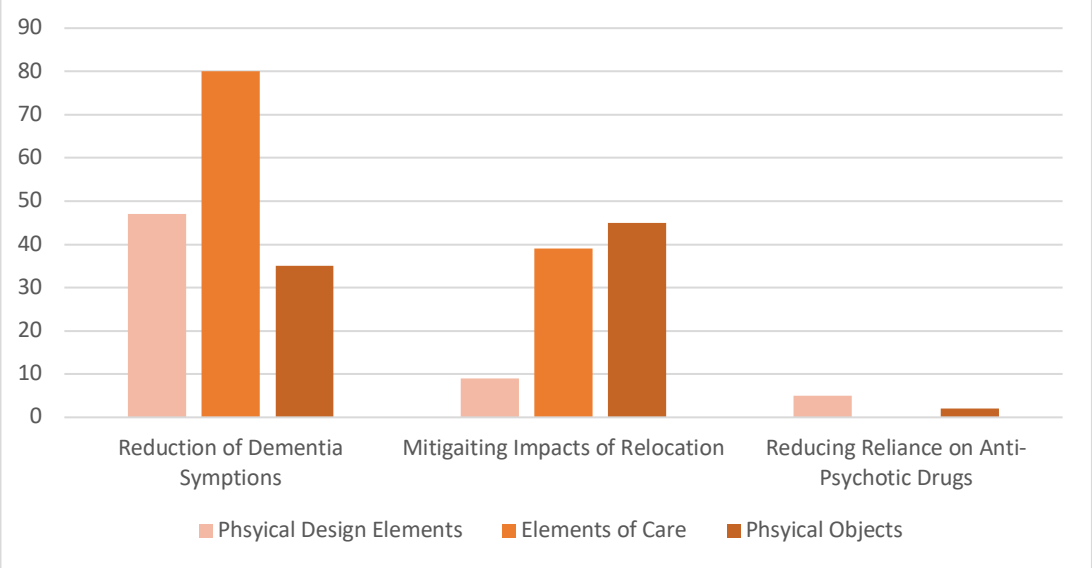
What factors contribute to a sense of home for residents in long-term care and how do these factors impact residents' health and wellbeing?

The first of my research questions asks what specific factors contribute to a sense of home for residents in long-term care, and how do those factors impact residents' health and wellbeing? To answer this question, I employed the codeset detailed above, noting the incidence and ways in which the factors contributing to a sense of home, as suggested within the literature review, impacted the health and wellbeing of long-term care residents. This impact, as noted in the conclusion to chapter two, has largely been through the reduction of behavioural symptoms, mitigating the impact of relocation, or reducing the reliance on anti-psychotic drugs. I had expected that codes would emerge through my research as important to creating a sense of home for residents in long-term care environments, and as improving the health of residents through the three methods mentioned. It was revealed through applying the codeset to the sample set of narrative reports on resident experiences that while this expectation was largely correct, the factors or codesets were not equally influential, and some, such as ceiling height, were employed in ways that I had not predicted.

Figure 1.1 (below) displays the incidence at which the factors of physical design elements, elements of care, and the presence of physical objects were noted within my research as reducing the behavioural symptoms, mitigating the impact of relocation, and reducing the reliance on anti-psychotic drugs. While only my primary codeset is demonstrated directly in this

figure, the secondary and tertiary codesets are reflected within their respective primary code. The results of this are as follows. Physical design elements were identified in the literature as reducing behavioral symptoms 47 times, mitigating impacts of relocation nine times, and reducing reliance on anti-psychotic drugs five times. Care elements were identified in the literature as reducing behavioral symptoms 80 times, mitigating impacts of relocation 39 times, and never mentioned with regard to reducing reliance on anti-psychotic drugs. Physical objects were identified within the literature as reducing behavioral symptoms 35 times, mitigating impacts of relation 45 times, and reducing reliance on anti-psychotic drugs twice. Through the remainder of this chapter, therefore, I will present in detail the trends associated with each code as identified by my research as well as industry produced recommendations.

Figure 1.1: Incidence of Factors Creating a Sense of Home in Relation to Improvements in Resident Health and Wellness



4.1 PHYSICAL DESIGN ELEMENTS

In researching how physical design elements of long-term care facilities (a primary code) contribute to a sense of home and impact the health and wellbeing of residents, I identified three secondary codes with several associated tertiary codes. The secondary and tertiary codes were as (1) private rooms (tertiary: privacy), (2) design elements limiting distractions and triggers for residents (tertiary: cleanliness, low ceiling height, lighting, colour of walls and floors, and hidden medical facilities such as nursing desks), and (3) design elements that facilitate the continuation of familiar daily routines for residents (tertiary: small structural layout, cottage-like design, resident accessible kitchen, resident accessible laundry room, resident accessible office space, a salon within the facility, and a family style dining room). In testing these codes, I was surprised by the few mentions of the role of private rooms and privacy in general in impacting health and wellness of residents, and also by the ways in which tertiary codes, such as ceiling height, were present but not as I had expected based on the literature review. Beyond those unexpected outcomes, however, my original beliefs about how the codes would emerge proved to be largely correct, as I will now demonstrate in detail.

4.1.1. Private Rooms and Privacy Measures

Based on the emphasis on private rooms found within the literature review, I had expected that private spaces and privacy measures would also be a prominent code throughout my research. I was, however, incorrect. Private rooms specifically were not discussed at all within the case studies analyzed, though the idea of privacy seemed to be underlying most texts, even if not directly stated. In fact, Welsh (2021) prefaces her study on how the right living arrangements can drastically improve the lives and health of seniors with the statement that long-

term care facilities need not be a dreaded place of finality for people, but rather spaces that foster love, dignity, and privacy (Welsh, 2021, p.xxvi). Further, the idea of privacy is directly mentioned only once in the 2015 report on best practices in long-term care, discussed as central to the United Kingdom alternative care system which, if adopted in Canada, could result in improved health and wellness for residents (Baines and Armstrong, 2015, p.65). The idea of privacy or private rooms was not discussed in any of the other sources consulted for this research. Though I was initially surprised by this fact, I suspect it may be due to private rooms already being an industry standard in other provinces throughout Canada, as well as in other countries, where there are more privately operated facilities offering private rooms to remain competitive in the market, and therefore less literature arguing for private rooms being produced (Canadian Institute for Health Information, 2021a). This difference in standards may be due to the series of budget cuts to long-term care funding by the Nova Scotia government in 2015, 2016, and 2017, which prevented existing facilities from being updated and new ones from being built to reflect the trend of single-bed rooms occurring elsewhere (Munro, 2022; The Canadian Press, 2016; Walsh, 2016).

4.1.2. Ceiling Heights

In my literature review, ceiling heights, particularly low ceiling heights, emerged as a physical design element that may contribute to a sense of home through replicating the typical rooms size in family houses, rather than in clinical institutions such as hospitals. As such, ceiling heights were used as a tertiary code in my research, one contributing to reducing distractions or the triggers associated with a medical environment. In the 2015 best practice recommendations, Baines and Armstrong do note once the potential influence of ceiling design in creating a more

home-like environment once, explaining that hallways with carpeting and ceiling pot lighting feel more like a home and less like an institution, useful in counteracting wandering or elopement, a significant risk for residents with behavioural symptoms (p.67). While this does not directly mention ceiling height, it does reflect the use of ceiling design in the way I had expected, to resemble a family home more closely.

The work of Welsh (2021), on the role of ceiling heights in creating an environment that contributes to resident health and wellbeing, provides important insights, but in a way that I found completely unexpected. She describes how in a number of "butterfly homes", modern, small care homes designed to offer an alternative to historically institutional facilities, soaring ceilings of heights up to 50 feet were combined with natural light and building materials to provide communal spaces for residents that were calming and avoided feeling claustrophobic (pp. 25-26, 39, 51-52). While this may in no way resemble the typical family home, Welsh (2021) explains that these modern facilities are often privately operated, and therefore costly. Those who could afford to receive care in such an environment would likely be accustomed to a luxury lifestyle, one that allows for black-tie dinners and formal receptions to continue in the familiar routines of residents prior to admission (pp.51-52). Therefore, while ceiling heights were used here in an unexpected way, the goal is similar to those methods discussed in this research as improving the health and wellness of residents, by delivering care in new environments.

4.1.3. Expected Incidence of Reduced Distractions and Familiar Routines

Other than the low incidence of private rooms and unexpected utilization ceiling heights, the remainder of the secondary and tertiary codes for physical design elements occurred as I had

hypothesized. Cleanliness of the environment is noted as not only effective in reducing distractions that may trigger behavioural symptoms, but also as a way for staff and residents to engage with one another in a meaningful activity, thereby allowing residents to physically maintain skills and dexterity, while preventing isolation and loneliness (Baines and Armstrong, 2015, pp.38-40, 42-45, 47-62; Picard, 2021, pp.92-101). Similarly, having residents involved in or even responsible for daily tasks in accessible spaces helps to maintain physical skill, allows for meaningful activity and social engagement (Welsh, 2021, pp.10-12, 18-20, 87-90). Additionally, Welsh (2021) explains how the involvement of residents in the preparation of meals encourages them to eat and enjoy the food more, helping avoid the risk of malnutrition associated with progressive diseases (p.18).

Soft or natural lighting, rather than the fluorescent lighting usually found in clinical environments is used to make hallways seem cozier and to create a comfortable mood in bedrooms. Welsh (2021) explains how one modern care home includes a family suite for residents to host visitors in, set up like a luxury hotel room. In one example, she details how a male resident was having his behavioural symptoms triggered by high-libido and relative isolation in the care environment. The resident's wife and the care home operators worked together to come up with a plan to employ a sex worker, who would spend an evening with the man in the comfortable family suite. The resident subsequently relaxed and experienced a reduction in behavioural symptoms for up to a month after the encounter (pp.118-119). The colours of walls and floors and the lack of visible clinical elements such as nursing desks or charts were discussed in a similar way, as being purposefully designed to contribute to a home-like rather than institutional environment and avoiding triggering behavioural symptoms (Baines and Armstrong, 2015, pp.54-63; Welsh, 2021, pp.5-6, 31-33).

Accessible salons and office spaces, family-style dining rooms, and cottage-like designs for facilities were also detailed as physical design elements that contribute to a sense of home and improve the health and wellbeing of residents in long-term care, particularly through allowing residents to continue in familiar daily routines. For example, Welsh (2021) offers an incredible account of a woman with behavioural symptoms who was struggling after relocation to a care program, remaining distraught for days until the program coordinator had the idea of presenting her with an office space and some work on financial books; the woman had been an accountant for her entire career and was immediately engaged with and calmed by the task at hand, one with which she was intimately familiar (pp.71-79).

4.2 ELEMENTS OF CARE

In researching how elements of care in long-term care facilities (a primary code) contribute to a sense of home and impact the health and wellbeing of residents, I identified four secondary codes with several associated tertiary codes. The secondary and tertiary codes were as follows: (1) meaningful activities (tertiary: continuation of familiar routines, folding laundry, cooking, gardening, and scrapbooking), and (2) social engagement (tertiary: pets/domestic animals, resident relationships with other residents, resident relationships with staff, and engagement in socio-cultural roles), (3) continuation of familiar daily routines for residents, and (4) autonomy. A number of these codes have already emerged as themes even in looking at physical design elements, such as familiar routines, laundry work, and cooking, demonstrating how the primary, secondary, and tertiary codes overlap and interact with one another, which will be addressed further in the proceeding section.

Additionally, while most of the secondary and tertiary codes for elements of care occurred numerous times and as expected throughout my research, there were two unexpected findings. First, that scrapbooking or even crafting, which was emphasized as a meaningful activity in the literature review was only noted once in all of the texts analyzed. Second, my research showed that while resident relationships with other residents does play an important role in socialization, there are also significant drawbacks associated with these interactions. We can now proceed to look at each of the codes employed in greater detail.

4.2.1. Overlapping and Interacting Codes: Routines, Laundry, and Cooking

As previously mentioned, the continuation of familiar daily routines, participation in laundry processing, and assisting in cooking are all secondary and tertiary codes that were accounted for either direct or indirectly under the primary code of physical design elements and the primary code of elements of care. Included in the discussion on physical design elements under the tertiary codes for accessible kitchens and laundry rooms, as well as a structural layout that facilitates the continuation of daily routines, the resulting impacts on resident health and wellbeing are the same. Allowing for a familiar routine and engagement with meaningful activities has been shown to reduce behavioural symptoms is residents, as well as helping them to maintain physical skills and dexterity while preventing social isolation and malnutrition and the associated negative health impacts (Baines and Armstrong, 2015, pp.38-40, 42-45, 47-62; Picard, 2021, pp.92-101; Welsh, 2021, pp.10-12, 18-20, 87-90). Noting the overlap and interaction between these elements, therefore, serves to further emphasize their importance and role in resident health.

4.2.2. Scrapbooks (Crafting)

The first unexpected result of my research on elements of care was the low incidence of scrapbooking, or even the more general term of crafting. Scrapbooking had been discussed as a meaningful activity in which residents can engage several times within the literature review, and therefore using grounded theory, I had expected it to also be discussed in the narratives texts of resident's lives in care to which the codeset was applied. I was incorrect; while scrapbooking did not occur at all within the texts, the generic category of "crafts" were discussed once as a meaningful activity for residents, in a case study on the delivery of long-term care in Germany. In this study, presented by Baines and Armstrong (2015), it was explained that staff to resident ratios of 1:3 or 1:4 allow for staff to have ample time to complete mandatory tasks and still be able to engage socially with residents through games, doing crafts, or holding conversation (p.48). This not only helped prevent residents from wandering (a common behavioural symptom) due to boredom, but also allowed staff to learn and appreciate the tastes and preferences of residents, facilitating better care and nutrition (pp.48-49).

Therefore, while the incidence of scrapbooking or crafting was lower than I expected, when it did occur it presented in the manner expected, and we can further note once again the overlapping of codes, where meaningful activities overlap with social engagement and resident-staff relationships. This low incidence may be due to the funding and staffing levels required allow for crafting activities, as is noted by the Institute for Continuing Care Education and Research's 2015 report on recreation services and quality of life (pp.i-ii), though this is not a hypothesis I am able to further explore within the scope of this project.

4.2.3. Resident-Resident Relationships

In addition to the low incidence of scrapbooking or crafting appearing within the texts, I was also surprised at how residents' relationship with other residents, while frequently mentioned, were discussed both from a positive and negative perspective. In presenting their recommendations for best practices in the long-term care industry, Baines and Armstrong (2015) highlight the benefits of residents working together on communal, meaningful activities including cooking, tidying, and performing music (pp.48, 52, and 79). They argue that this contributes to a more home-like feel in the environment, in which residents can become comfortable with one another and exercise autonomy as well as skill (p.47). In contrast, while Welsh (2021) briefly discussed the role of resident interactions with one another through conversation and debates which allow for socialization and the exercise of mental ability (pp.33-34), she further notes a number of negative aspects of resident interactions, particularly those between residents in differing stages of cognitive decline. For example, residents with advanced cognitive decline or behavioural symptoms not recognizing personal space in dining areas can cause others to become uncomfortable and rush through meals, meaning the interactions with those with whom they may have wished to dine are limited, and their food is hurried rather than enjoyed (pp.141-142). These issues should not be understated, as they may possibly exacerbate the already significant risk that residents face of experiencing social isolation not to mention malnutrition.

4.2.4. Expected Incidence Remaining Codes

The remainder of the primary, secondary (meaningful activities, social engagement, continuation of familiar routine, and autonomy), and tertiary (gardening, pets/domestic animals,

resident-staff relationships, and socio-cultural roles) codes occurred largely as suspected. Gardening was discussed by both Baines and Armstrong (2015, pp. 55, 35, 44, and 54) and Welsh (2021, pp. xvii, 29, 70, 72, 101, 103, 146, 158, and 176) as a meaningful activity helping slow the physical and mental decline associated with progressive disease while creating a sense of purpose, as well as a source of encouragement for residents to eat nutritious foods that the grew themselves. Social engagement was highlighted as key in preventing the negative health impacts associated with social isolation in residents with behavioural symptoms (Baines and Armstrong, 2015, pp. 49, 36, 37, and 48; Welsh, 2021, pp. xxv, 66, 81, 127, 137, 167, 199, 204, and 206). Welsh (2021) details how both the presence of pets and geographical proximity to farms so that residents can hear and see domesticated farm animals serve as an opportunity for social engagement and continuation of familiar daily routine for residents who grew up in farming communities (pp. 126-127).

Resident and staff relationships were identified in all the texts as an imperative source of social engagement and one that is rewarding not only for residents but also for staff, whose emotional ability to connect with residents and give high quality care is subsequently improved (Baines and Armstrong, 2015, pp.39; Picard, 2021, p.57; Welsh, 2021, pp.xi, 34, and 140). Lastly, Welsh (2021) places particular emphasis on the importance of residents engaging in either familiar or new socio-cultural roles, such as working in an office, acting as a tour guide, or landscaping (pp.89, 141, 170). This, Welsh (2021) argues, offers a trifecta of meaningful activity, social engagement, and the continuation of familiar routines, as well as the health and wellbeing impacts associated with each.

4.3 PERSONAL OBJECTS

Throughout the literature review, the presence of personal objects within a long-term care facility, and the accessibility of these objects for residents, led to the creation a set of secondary (personal objects, photos/pictures, wardrobe items/accessories) and tertiary (presence of personal items, use of personal items in daily routine, personal items and sociability, handbag/purse, jewelry, clothing) codes with which to analyze the researched texts. My research revealed that these codes acted largely as expected, with the exception of jewelry not occurring within the texts with the definition employed by this research (refer to Figure 1.0). With that being said, let us now looking at each of the codes that did occur within texts with greater detail.

4.3.1. Any and All Personal Objects

As suggested within the literature review, the mere presence of personal objects was stated by the source texts for this research as contributing to a sense of home for residents, particularly those objects with which a resident could freely interact of their own accord. This, Baines and Armstrong (2015) argue, offers meaningful engagement, mental stimulation, and a sense of independence, which, as already demonstrated above, may contribute to a reduction of behavioural symptoms and could mitigate the impact of relocation on residents (pp.64-65). Welsh (2021) further discusses the impact of residents having access to personal items in general. For example, Welsh (2021) explains how one woman regularly handles a box of love letters from her late husband, replacing her daily interactions with him with the physical letters he left for her (pp.47-48). The positive impacts of this routine include allowing her to still engage with her socio-cultural role as a wife and serves as an engaging activity that helps to slow the cognitive decline.

Welsh (2021) provides a further example of how more modern personal objects can facilitate the daily routine and social ability of residents, explaining how a small tablet can act as a smartphone by allowing a resident to select one of two images of family members on the device and have it call them without requiring her to remember their names or how to write out messages for them (pp.75-80). This allows for a familiar routine with some sense of independence and offers important social engagement. Likewise, a personal item such as a pajama set can facilitate social interactions and reduction in distractions for residents, by allowing staff to join them while similarly clothed to have a slumber party. The welcome presence of a another person for individuals not accustomed to sleeping completely alone is a social opportunity and improves quality of sleep, thereby reducing the behavioral symptoms that typically are treated with anti-psychotic drugs (pp.59-61).

4.3.2. Photos/Pictures

Photos and/or pictures occurred numerous times within the source texts for this research, with particular use in trigger the memories of residents, either to aid them in finding their rooms, remembering which door leads to the bathroom, of facilitating recollections of their life stories, friends, and family. Baines and Armstrong (2015) explain the value of keeping photos of residents on hand for affixing to their doors to aid in finding their rooms, as well as encouraging social interactions between residents and with staff (pp.63-64). Further, when addressing how photos can shape interactions between residents and staff, Welsh (2021) details a care home in which staff members are individually professionally photographed, and their images and biographies displayed in the facility for both residents and their families to become familiar with,

eliminating a number of social barriers that might otherwise exist between residents and those employed to care for them, and facilitating social interaction (pp.59-61).

4.3.3. Wardrobe Items and Accessories

Lastly, while I did encounter the unexpected result of jewelry not occurring as a tertiary code under the secondary code of wardrobe items and accessories, handbags/purses and various clothing items were mentioned. Handbags and/or purses were discussed frequently by Welsh (2021), who notes how one resident carries a red handbag with her at all times as she navigates through the facility in which she resides, carrying in it items to touch up her appearance such as tissues and lipstick, allowing her an expression of autonomy, continuation of familiar routines, and an opportunity to exercise the physical skills and dexterity associated with carrying the bag and using the items within it (pp.4-9). Handbags are similarly utilized by other female residents, including one who spend hers days working on fabricated accounting sheets in the facility office. Each morning she dresses for work and packs her handbag, before spending the day the same way she had throughout her professional career (pp.78-80).

Clothing also plays a role in creating a sense of home for residents and improving their health and wellbeing. One upscale private facility hosts formal balls, for which residents dress up in black tie attire and socialize with residents, staff, and family in an atmosphere that is familiar for their lifestyle (pp.52-54). For those residents who engage in daily activities that resemble their previous careers, work clothes aid in carrying out a familiar routine and provide an opportunity to exercise skills such as buttoning shirts and tying shoes (pp.79-80). Essentially, familiar clothing allows residents to maintain their sense of self, even when being cared for

amongst dozens of others, which may serve to facilitate a sense of belonging, and therefore being at home in the environment.

The results of this analysis showed that the incidence and occurrence of many of the codes identified through the literature review proved to be correct within the context of the narrative reviews against which they were tested. In particular, codes relating to limiting distractions, and continuation of familiar daily routine emerged as prevelant and important factors impacting a sense of home in long-term care and contributing to resident health and wellbeing.

A few codesets and associated theories did, however, prove to be incorrect or inappropriate when applied to the narrative reviews of resident life in long-term care. The role of privacy or private rooms, for example, was either disregarded entirely or noted as unimportant. For these reasons, the codeset was revised and applied separately in light of these findings when analyzed alongside the specific COVID-19 long-term care restrictions discussed in the proceeding section of this research.

CHAPTER 5 COVID-19 RESTRICTIONS AND HOME-LIKENESS

What restrictions were imposed in long-term care facilities in response to the pandemic, and how might these restrictions impact the health and wellbeing of residents?

When asking in what ways COVID-19 restrictions and public health policies impacted the immediate and long-term organization of long-term care in Nova Scotia, both policy documents themselves and media reports on resident and family accounts reveal the extent to which restrictions interrupted the daily lives and sense of home experienced by those in long-term care. In this section therefore, I will present policy and media documents related to each element contributing to a sense of home in long-term care detailed in the previous chapter: (1) physical design elements, (2) meaningful activities, and (3) personal objects.

The restrictions likely to be most impactful on the physical design elements identified by this research as important to creating a sense of home in long-term care are as follows: the implementation of isolation wards and rooms, requirements for increased signage, masking, and screening stations, salon and dining room closures, cohorting requirements, gathering limits, visitation limits, and kitchen closures to residents. Likewise, visitor restrictions, gathering limits, and isolation requirements, with the addition of social distancing rules further impact the ability of residents to engage in meaningful activities. Lastly, the role of personal objects in creating a sense of home for long-term care residents was demonstrably limited through new environmental services policies, such as not permitting unnecessary objects in isolation rooms and limiting usage of objects to those that can be cleaned according to IPAC standards. The remainder of this chapter will explore each of these elements in further detail, analyzing the media reports and policy

documents to argue the full effect of the restrictions on the sense of home experienced by residents in long-term care.

5.1 ISOLATION ROOMS AND WARDS

The implementation of isolation rooms and wards was one of the first restrictions introduced for residents of long-term care at the onset of the COVID-19 pandemic. In the original version of the *COVID-19 Management in Long-Term Care Facilities Directive*, released on April 6th, 2020, a 14-day isolation period was imposed for all new residents being admitted to a facility, under section 2.2. This isolation period was to take place within the facility, and residents who were already admitted to the facility but who had taken temporary leaves (e.g., to the hospital, outside medical appointment) had to be screened for risk of exposure to the virus while on leave, and were to also be placed in a 14-day isolation period is exposure was deemed to have occurred.

Furthermore, section 4.3 of the April 6th, 2020 *COVID-19 Management in Long-Term Care Facilities Directives* imposes isolation requirements for any residents who had tested positive for COVID-19 or those presenting with COVID-19 symptoms, and offers a more detailed look at what these full isolation measures actually consisted off. Section 4.3 states that measures for residents on isolation include placing residents in private rooms, utilizing partitions such as curtains, providing meals in the resident's room, disallowing participation in any group activities, the wearing of PPE for all staff and visitors inside the facility, and highly visible signage indicating precuation levels.

In November of 2020, off-site isolation units for long-term care residents were introduced by the Nova Scotia Department of Health and Wellness (CBC News, 2020). These six isolation

units were referred to as Regional Care Units ("RCU"), with one designated for each of the regions of the province. Long-term care residents who tested positive for COVID-19 were to be transferred out of their home facility and into their offsite RCU. These RCUs were spread across the province (CBC News, 2020).

In October of 2021, updated screening and isolation were introduced in the *Coronavirus Disease 2019 (COVID-19): Infection Prevention and Control Guidelines for Long Term Care*. Section B, detailing the protocols for screening of residents, stated that all newly admitted or re-admitted residents must have received a PCR test for COVID-19 prior to their admission. Should the test result not have been available at the time of admission, the resident was required to isolate (with droplet and contact precautions), until a negative test result was received, regardless of vaccination status. Admissions from community were assessed for vaccination status, and isolation (droplet and contact precautions) were required on admission for 14 days if the resident is not considered fully vaccinated. Those residents testing positive for COVID-19 upon admission or during the in-facility isolation period were transferred to the appropriate off-site RCU.

The most recent directives for resident isolation were updated on July 20th, 2022 in the *Guidance for COVID-19 Case Management and Outbreak Control in Long-Term Care Facilities* document released by the newly created Department of Seniors and Long-Term Care. This document set out the isolation regulations for case management of residents with a confirmed or suspected COVID-19 diagnosis, including:

- Isolating the resident and implementing droplet and contact precautions;
- Preventing dining with others, attending group activities, and attending non-essential appointments;

- Requiring residents wear masks and their rooms be highlighted as high risk by signage.

Therefore, it is clear that isolation of residents played an important role in early and sustained COVID-19 infection prevention and control efforts in long-term care facilities. These restrictions, however, would have also had an impact on the ability of long-term care residents to experience a sense of home, in the context that a sense of home has been defined thus far in this research project. Isolation of newly admitted residents would have prevented early familiarization with the staff and physical building, and created an inability for new residents to maintain a familiar daily routine or socialize with visitors, which has already been established as essential to place-making and creating a sense of home in the sections above. Interacting only with staff in full contact and droplet precaution personal protective equipment ("PPE") is a highly clinical experience, and not something one would associate with feeling comfortable in their own home.

Likewise, even for residents who previously had the opportunity to become familiar with the long-term care environment, isolation would have disrupted their daily routines for dining or socializing with others, free navigation of the facility for independent activities such as gardening, and visitation with family or friends. Further, upon the introduction of isolation wards, residents would have been moved out of their own rooms, forced to leave behind personal belongings and the familiar environment. Here too, the experience of interacting only with staff wearing PPE would have clinicalized their daily routine, as the human experience of socialization and its role in maintaining health was de-emphasized in light of the medical practices associated with COVID-19. Those with private rooms would also have lost that sense of privacy upon relocation to the isolation ward. As these isolation restrictions are still in place, it

is also likely that a resident may have gone through the cycle of isolation, re-introduction to general facility, re-familiarization with other, exposure to virus, and re-introduction of isolation more than once, preventing maintenance of a familiar daily routine and a sense of home which this paper has demonstrated is essential for health and wellbeing.

5.2 MASKING AND SIGNAGE

A second physical design element noted within this research as detrimental to a sense of home in long-term care is the presence of visible medical or clinical items. In analyzing the policy documents and media reports on the COVID-19 restrictions introduced to long-term care facilities, two efforts medicalizing the daily environments of residents were prevalent and long standing: masking and signage.

Restrictions requiring signage were introduced in the April 2020 *COVID-19 Management in Long-Term Care Facilities Directive,* which stated that signage was required to be posted at all entrances and exits throughout the facility to advise staff and essential visitors that an outbreak has been declared in the unit/facility. Further, the signage was required to have included instruction for cleaning hands when entering and exiting the facility, reminders that ill visitors must not visit, and that visitor restrictions are in effect. The *Directives* at that time also required that any resident requiring droplet and contact precautions have a sign placed to be visible on the resident's door or in the resident's bed space indicating such. As of July 2022, these requirements were still in place per the *COVID 19: Long Term Care Plan of Care for Resident with Suspected or Confirmed COVID-19 Infection* Document.

As with signage, masking requirements for long-term care staff and visitors were one of the first restrictions implemented at the onset of the pandemic, though it is argued not soon

enough. In Nova Scotia, much media attention was given to the Chief Medical Officer's delayed implementation of masking requirements for staff, despite early federal recommendations for the use of surgical face coverings (Flanagan, 2020; Jerrett, 2020; Rankin, 2020; Ray, 2020). When mask requirements were introduced on April 13th, 2020 by the Department of Health and Wellness, outbreaks in Nova Scotian long-term care facilities had already begun, and the provincial government had announced three resident deaths as a result of the virus (Ray, 2020). Perhaps the extent of the resulting critique surrounding the delay in masking requirements is why, as of December 2022 when almost all COVID-19 restrictions in the long-term care have been removed, masking remains required for staff, per the current *COVID-19 Management in Long-Term Care Facilities Directive*, issued in July of 2022. Additionally, visitors are required, and residents are encouraged to wear masks in common areas within long-term care facilities, as stated in section 2.4.

As infection prevention and control signage and surgical masks requirements remain in place, the daily lives of long-term care residents remain then, clinicalized. For residents without any symptoms of COVID-19, their every interaction with staff members is around a mask. Facial expressions are hidden and for the hard of hearing, communication is muffled. For those residents with COVID-19 symptoms or otherwise on contact and droplet precaution protocol, the very spaces they occupy are marked with signage.

5.3 CLOSURE OF FACILITY SPACES

In addition to the implementation of isolation rooms and wards, infection prevention and control signage, and masking, there was another substantial change to the physical environment of residents that would have likely impacted their ability to experience a sense of home in long-

term care facilities: the closure of common spaces. Throughout the first wave of COVID-19 in Nova Scotia, many common areas in facilities were closed, including salons, recreation areas, and dining rooms (Government of Nova Scotia, 2020; Henderson, 2020). Salons and other on-site hairdressing services were unable to resume until September of 2020, at which time licensed hairdressers were able to develop and submit safety plans to their respective facilities for approval by the DHW (Government of Nova Scotia, 2020, p.10).

Although recreation areas and dining rooms appear to also have been ordered to close at that time, it is not evident when they were permitted to reopen. In April of 2020, when the initial *COVID-19 Management in Long-Term Care Facilities Directives* were released, section 2.4 codified a previous health order that had been implemented at the end of March, that all efforts to maintain social distancing must be made, including the staggering meal times, maintaining physical distance of two metres or six feet, and limiting group activities to less than 5 people total inclusive of staff supporting the activity (pp. 6-7). This restriction, however, made it unclear whether residents were taking their meals in their rooms or still permitted to gather to some degree in the dining room and for activities in recreation areas. Reporter Jennifer Henderson (2020), of the *Halifax Examiner*, reached The Department of Health and Wellness for clarification within days of the initial order being made, but the DHW said it was unable to confirm whether those common areas were ordered to close. Henderson (2020) did, however, receive confirmation from a representative of an organization which operates numerous long-term care facilities across the province, that dining rooms and recreational areas were closed. It is unclear from a full analysis of policy and media documents when these areas were reopened, though the closures were not mentioned in subsequent governmental directives.

5.4 VISITOR RESTRICTIONS

Long-term care facilities in Nova Scotia initially closed to visitors on March 15th, 2020 as a result of orders under the *Health Protection Act* when the first three presumptive cases of COVID-19 were announced in the province (Chisholm, 2020; Government of Nova Scotia, 2020). They would remain closed for non-essential visitors for three months, until June 10th, when outdoor, socially distanced visitation were permitted, with the following precautions in place (Government of Nova Scotia, 2020):

- visits were only to take place outdoors, in designated areas on the facility's grounds, with a maximum of two visitors may attend at one time, while maintaing physical distance of two metres;
- visitors were required to be screened for COVID-19 upon entry and wear a non-medical mask, anyone with symptoms will not be permitted to enter and visitor information was required to be logged, including date and time of visit to the facility;
- visitors who are self-isolating were not permitted to enter the facility or grounds and visits were to be monitored by staff, who would escort visitors to the designated area and provide PPE if needed.

Of all the COVID-19 restrictions imposed in long-term care, however, visitation remained the most in flux, and due to rising cases in November of 2020, visitation was once again disallowed, only to resume with virtually no notice on December 21st, 2020 (Petracek, 2020). Although facilities have generally remained open to visitors since then, those with declared outbreaks continue to close for visitation. These outbreaks, which may be declared with as few as two residents testing positive in a unit, can lead to lockdown situations for all residents for up to ten days, and are happening on an ongoing, repeated basis (Draus, 2022).

5.5 COHORTING, SOCIAL DISTANCING, AND GATHERING LIMITS

Social distancing restrictions were also introduced through an early Order by the Medical Officer of Health, issued on March 24th, 2020, stating that all efforts to maintain social distancing must be made within facilities, staggering mealtimes, maintaining physical distance of two metres/six feet, and limiting group activities to less than five people total inclusive of staff supporting activity (Government of Nova Scotia, 2020). In December of 2020, social distancing requirements within facilities were eased but cohorting restrictions came into place, mandating that facilities cohort the same residents together each time and maintain consistent programming staff (Government of Nova Scotia, 2020). At all times, however, long-term care facilities were still subject to the province wide gathering limit restrictions, meaning that when COVID-19 waves continued to require public health interventions such as limiting gatherings to household only, these rules would be reflected within facilities as well (Government of Nova Scotia, 2020).

As of July 2022, restrictions remained in place regarding cohorting and social distancing (Government of Nova Scotia, 2022a). These restrictions in particular limited the ability of residents to maintain sociocultural roles, engage in meaningful activity, and participate in socialization, which as noted already, are essential in creating a homelike environment in long-term care environments.

5.6 ENVIROMENTAL SERVICES

Lastly, restrictions regarding environmental services procedures would have had a major impact on the clinicalization of the environment of long-term care residents, as increased

cleaning was implemented in both resident rooms and common areas, and environmental service workers would have been required to wear at minimum a mask and potentially up to full PPE.

Meeting these requirements involved frequent interruption to the daily routines of residents, interruptions that would not have occurred within their own home, by staff uniformed in environmental services attire and PPE. Activities requiring the sharing of materials or items, such as gardening tools, crafting tools, the folding of laundry, or the preparation of food would have been prevented by these restrictions. Additionally, I would suspect that repeated sanitization of areas frequented by residents may give individuals living in long-term care settings the sense of being "dirty" or unwelcome, thereby further limiting the homelike atmosphere of the environment and increasing the degree of clincalization of their lives through infection prevention and control practices.

The potential impacts noted thus far of the COVID-19 restrictions on long-term care residents reflect the concerns of the families and friends of residents, as well as nursing professionals, who brought attention to the reality of life in facilities during the pandemic. In August of 2020, just a few months after the initial restrictions had come into place, a small protest occurred outside of the Northwood Campus long-term care facility in Halifax, Nova Scotia. During the protest, those participating expressed both their own perspectives of the restrictions as preventing families from ensuring their loved ones were receiving proper care, and the previously articulated opinions of residents as feeling like prisoners (Thomas, 2020). Frequent stories were also reported around this time about families concerned that their loved ones who lived in long-term care were experiencing the final years of their lives without access to family or friends, claiming the government had overlooked the needs of this vulnerable population (Bains, 2020; Ryan, 2020).

Similar sentiments were expressed when CBC News interviewed Elaine McDonald, a resident at Saint Vincent's nursing home, also in Halifax, in March of 2022. McDonald was interviewed following the relaxation of visitor restrictions and stated that she was excited to visit her son at his home after feeling like she was "in jail" when full restrictions were in place (CBC News, 2022). A month later, in April 2022, the Executive Director of the Nova Scotia Nursing Home Association, Michele Lowes took to the media to voice her concerns over the impacts the restrictions had had on residents (Draus, 2022). Lowes claimed that for those with dementia, contact with family and maintaining a regular routine were essential in supporting wellness, and that when lockdowns prevented visits and interrupted established routines, the health and wellbeing of residents was noted to decline (Draus, 2022).

Having set out those COVID-19 policies enacted in Nova Scotia that overlap with the factors contributing to a sense of home in long-term care as demonstrated by this project, it is now possible to predict the possible impact of these restrictions on the health and wellbeing of residents in long-term care facilitates. In doing so, three types of predictions can be made. First, those that appear most probable, in that they result from the tested codeset presented in chapters three and four. Second, those less probable predictions based on the restrictions as they relate to the larger literature review presented in chapter two. Lastly, the larger, more general predictions made as a result of restrictions contributing to the clinicalization of care, they theory of which is established in chapter one. The result of this analysis should therefore be a comprehensive set of predicted, measurable, potential health impacts of the COVID-19 long-term care policies in Nova Scotia, that may be operationalized in future research studies to reveal the full and actual impact of such restrictions on the health and wellbeing of long-term care residents.

5.7 PREDICTIONS IMPACTS BASED ON CODESET

Based on the findings resulting from employment of the codeset, analyzed in light of the COVID-19 policies set out in the *Long-Term Care Directives* and other reviewed documents, the following predictions on the impact of restrictions on the health and wellbeing of long-term care residents can be made:

(i) Incidence of behavioral symptoms would likely have increased throughout the duration of the policies being in place;

(ii) More reliance on anti-psychotic drugs;

(iii) Levels of resident maintenance of skill and dexterity would likely have decreased;

(iv) Residents would have been at higher risk of malnutrition while restrictions were in place;

(v) Quality of resident care would have decreased;

(vi) Risk of residents experiencing isolation would have increased; and

(vii) Quicker rates of cognitive decline.

Predicating that the incidence of behavioral symptoms would likely have increased throughout the duration of COVID-19 restrictions being in place results from the introduction of clinical elements to care areas through those policies necessitating signage for handwashing, mask wearing, and isolation protocols, policies requiring the use of PPE, and those implementing commercial grade disinfection protocols in resident rooms and spaces with great frequency. Per Baines & Armstrong (2015, pp.54-63) and Welsh (2021, pp.5-6, 31-33), these visible clinical elements may lead to the triggering of behavioral symptoms in residents. It is further suggested by Baines & Armstrong (2015, pp. 64-65) and Welsh (2021, pp.59-61) that policies limiting

mental stimulation and meaningful engagement will also increase behavioural symptoms, therefore, those restrictions requiring the isolation and cohorting of residents to rooms or wards and limiting their opportunities for social engagement with each other or in broader activities such as mass will have led to increased behavioural symptoms. As the rates of behavioural symptoms increased, the codeset establishes there would have likely been a causational increase in the use of anti-psychotic drugs (Baines & Armstrong, 2015, pp. 64-65; Welsh, 2021, pp.59-61), and the health impacts associated with the use of such medications.

The results of employing the codeset further suggest that levels of resident maintenance of skill and dexterity would likely have decreased throughout the duration COVID-19 policies in long-term care, while cognitive decline would have occurred more quickly during this time. Use of the codeset identified that involvement of residents in the daily routines such as getting dressed and packing their handbags, participating in cleaning/tidying of their areas, and engaging in food preparation allows residents to physically maintain skills and dexterity (Baines and Armstrong, 2015, pp.38-40, 42-45, 47-62; Picard, 2021, pp.92-101; Welsh, 2021, pp.10-12, 18-20, 87-90). Therefore, long-term care restrictions requiring isolation of residents to their own rooms, cohorting to limit any interaction with only a set number of individuals per area, and the closure of facility spaces such as food preparation and dining areas, and those necessitating increased levels and frequency of cleaning, as well as the requirement to wear PPE while doing so, would have prevented resident involvement thereby reducing the opportunity to preserve the physical abilities associated with these tasks. Additionally, the lack of opportunity for resident involvement in the preparation of meals may have discouraged them from eating and enjoying the food more, and increased the risk of malnutrition associated with progressive diseases (Welsh, 2021, p.18).

The final predicted impact of COVID-19 restrictions on resident health and wellbeing is that these restrictions may actually have lowered the level of care that residents receive. Resident and staff relationships were identified by Baines & Armstrong (2015, pp. 39), Picard (2021, p.57), and Welsh (2021, pp. xi, 34, &140) as an imperative source of connection by which delivery quality of care is improved. Therefore, restrictions that limited resident and staff interactions such as the wearing of PPE, isolation protocols, cohorting with only certain staff members, and lack of engagement in activities facilitated by staff would all have limited the opportunity for resident and staff connections to occur, and increased the risk of levels of care being lowered.

5.8 PREDICTIONS IMPACTS BASED ON LITERATURE REVIEW

While the predicted impacts of COVID-19 restrictions on resident health and wellbeing based on the literature review are less supported than those suggested by the tested codeset, they are worth reviewing because their similarities to those already noted serves to further bolster and contextualize the codeset predicted outcomes. Therefore, based on the elements of care identified within the literature review, analyzed in light of the COVID-19 policies set out in the *Long-Term Care Directives* and other reviewed documents, the following predictions about the impact of restrictions on the health and wellbeing of long-term care residents can be made:

(i) Use of anti-psychotic drugs would have increased;

(ii) Levels of maintenance of physical skills, dexterity, energy levels, and cognition would have decreased; and

(iii) Rates of morbidity and mortality following relocation would have increased.

The increased use of anti-psychotic drugs as a result of COVID-19 restrictions on long-term care in Nova Scotia can be predicted as a result of the argument that the factors that contribute to creating a sense of home for residents in long-term care serve as a non-pharmacological alternative. The presence of these factors, identified within the literature review as include such things as meaningful activities like gardening and cooking, forming social connections, and familiar environments (Bigonnesse et al., 2014, p. 64-365 and 368-370; Board and McCormak, 2018, p.3073-3077; Hutchings et al. 2011, p.368-370), would have been disrupted by COVID-19 policies on isolation, visitation, cohorting, gathering limits, and closure of common spaces where meaningful activities and social connections could occur. As a result, the rates of negative side-effects associated with the use of anti-psychotic drugs, such as strokes and falls, would have increased (BC Patient Safety & Quality Council, 2015, pp.2-3).

Decreased levels of maintenance of physical skills, dexterity, and cognition as a result of COVID-19 policies are suggested by Leibrock's (2000) description of how activities such as folding laundry helps residents to maintain the physical skills and dexterity necessary to complete such tasks (p.40), and Hutchings et al's (2011) explanation that meaningful activities that reflect familiar routines and those that encourage reflection help improve the memory and stabilize the cognitive function of residents with dementia and other progressive diseases (p.228). Further, residents who engage in activities such as socializing, cleaning their space, or being physically active reported having a great degree of contentment and more energy (Førsund et al., 2018, p.21).Thus, isolation policies that would have prevented residents from engaging in tasks requiring dexterity and visitation, and common area restrictions that would interrupted their ability to partake in activities that reflect their established daily routines, such as tea with a

nephew or a visit to the salon, would have decreased levels of maintenance of physical skills, dexterity, and energy levels, and increased the rate of cognitive decline.

Finally, the literature review suggests that COVID-19 policies that restricted resident access to group activities and their ability to maintain and establish socio-cultural roles, such as those on visitation, isolation, and gathering limits, would have prevented mitigation of the increased morbidity and mortality rates associated with relocation to long-term care (Hutchings et al., 2011, p. 228). As a result, policies requiring newly admitted residents to be placed in isolation for days or even weeks, interacting in person only with staff in full PPE, would have been particularly detrimental to health and wellbeing.

5.9 PREDICTIONS IMPACTS BASED ON CLINICALIZATION OF CARE

Although included in the literature review, elements of clinicalization were not implemented through the codeset because the purpose of the codeset was to help establish which elements were identified as creating a sense of home in long-term care, and as demonstrated in the literature review, clinicalization seemingly limits the ability to create a homelike environment. As noted in analyzing the COVID-19 long-term care directives and other policies in chapter five, however, a number of the restrictions contribute to the clinicalization of resident care and, therefore, merit discussion here.

As a result of the COVID-19 policies on isolation, PPE, and environmental services, it is likely that residents in long-term care experienced increased clinicalization their daily routine, as the human experience of being a whole individual with needs of socialization, comfort, and belonging, and the role of the recognition of this wholeness and uniqueness in maintaining health, was de-emphasized in light of the medical practices associated with infection prevention

and control (Government of Nova Scotia, 2020). The result of this increased clincialization would have been to limit the ability of residents to experience a sense of home in their environment and, therefore, the healing potential of long-term care as a whole would have been decreased. While specific measurables are more difficult to identify here, it may be predicted that overall patient outcomes, particularly those relating to injuries or illnesses other than COVID-19, would have been worse throughout the duration of the policies being in-place.

5.10 EMERGING DATA ON PREDICTED IMPACTS

While data is still emerging as COVID-19 restrictions in long-term care settings continue to be lessened or removed globally, there is already some evidence that the impacts predicted through the research presented in this thesis are, in fact, occurring. A sampling of studies from regions where COVID-19 policies in long-term care facilities were similar to those in Nova Scotia supports the predicted outcomes of: (i) an increase in behavioral symptoms and isolation throughout the duration of the policies being in place, (ii) an increase in the use of anti-psychotic drugs, (iii) a loss of resident skills, dexterity, cognition, (iv) an increase in rates of resident morbidity and mortality following relocation to long-term care and (v) an increase in the rates of malnutrition.

Studies out of the Netherlands and the United States suggest that within six-to-ten weeks of COVID-19 restrictions, particularly those featuring visitors bans, being implemented, resident levels of behavioral symptoms and isolation began to rise over pre-pandemic levels (Simard and Volicer, 2020, pp.966-967; Stuart, 2020; Van de Roest et al., 2020, p.1569). These symptoms included agitation, depression, anxiety, irritability, aggression, and impulsivity (Simard and Volicer, 2020, pp.966; Van de Roest et al., 2020, p.1569). Further, Simard and Volicer (2020,

pp.967) and Van de Roest et al. (2020, p.1569) also identify increased rates of cognitive decline, mortality, and appetite disorders as occurring in residents subject to COVID-19 restrictions in long-term care, supporting further predictions made by this thesis on loss of cognition, greater risks of morbidity and mortality, and higher rates of malnutrition.

Increased rates of cognitive decline and behavioral symptoms, alongside skill/dexterity loss and higher rates of antipsychotic drug use for long-term care residents with dementia under COVID-19 restrictions, were also reported at a global level by Suárez-González et al. (2020), who summarize international research evidence to demonstrate that such restrictions were highly disruptive to resident lives and significantly impacted cognitive and functional outcomes (p.6). A few studies further support these findings but on a national level. Aubertine-Leheudre and Rolland (2020, p.975) also conclude from a conducted study in Montréal, Quebec that COVID-19 restrictions negatively impacted the functional abilities (include maintenance of skills and dexterity) in institutionalized seniors, while the Canadian Institute for Health Information (2022) demonstrates that since the onset of the COVID-19 pandemic, antipsychotic use rates have increased in long-term care in several provinces, including Ontario, Alberta, and British Columbia (p.48). Therefore, while the predictions made by this thesis are by no means conclusive, there is emerging evidence to support these claims on both international and national levels.

CHAPTER 6 CONCLUSION

The aim of this research is to contribute to a broader understanding of the likely impacts of the COVID-19 related restrictions in long-term care on residents' health and wellbeing through examining (1) what factors contribute to a sense of home for residents in long-term care and how do these factors impact residents' health and wellbeing and (2) what restrictions were imposed in LTC facilities in response to the pandemic, and how were these restrictions likely to impact residents' feelings of being at home. To engage with these topics, I undertook a detailed content analysis of (1) peer-reviewed literature on the impact of homelike environments on resident outcomes, (2) public statements and reports in the media on this issue, (3) in-depth, narrative reports of resident lives in long-term care published by social science and nursing professionals working in the field, and (4) COVID-19 Management in Long-Term Care Facilities Directives released by the Nova Scotia Department of Health and Wellness (Bernard et al., 2017).

Question one, articulating factors contributing to a sense of home in long-term care and their impact on the health and wellbeing of residents, was first explored through the development of a set of primary, secondary, and tertiary codes. Each of these codes, identified through theoretical sampling of the research area, represent a distinct idea (Martin & Turner, 1982, p.149). The use of primary, secondary, and tertiary codes allowed the codeset to best encompass and present each factor contributing to a sense of home and how those factors impact resident health and wellbeing. By employing this codeset to reveal the occurrence of each possible factor of home and its impact on the health of residents on a broad sample of peer-reviewed literature, I was able to identify those factors most important in creating a sense of home and wellbeing for residents of long-term care as: (i) the physical design elements of cleanliness, soft or natural

lighting, reduction of clinical elements such as nursing desks, and accessible spaces such as salons, office spaces, and family-style dining rooms, (ii) elements of care including the promotion of familiar routines through activities such as laundry and cooking, and opportunities for social engagement and maintenance of sociocultural roles, and (iii) the presence and use of personal objects, particularly photos and wardrobe items like clothing.

Then, applying the impact of these factors of home as set out in the literature review, the presence of these important factors of home in long-term care contribute to health and wellness in the following ways. First, through directly improving the health of residents through reduction of behavioural symptoms of common diseases and disorders in long-term care (Davies, 2018, p.86, Jessop et al, 2017, p.1392; Leibrock, 2000, pp.32-34; Chaudbury et al, 2017, pp.95-97; Kontos, 2011, pp.329-330). Second, through reducing reliance and overuse of anti-psychotic drugs and avoiding the associated negative side effects (Davies, 2018, p.86, Jessop et al, 2017, pp.1391-1392; Olsen and Albensi, 2021, p.427). Third, through mitigating the negative health impacts of relocation to long-term care (Hutchings et al, 2011,p.225; Ryman et al, 2019, p.675; Thorson and Davis, 2000, p.113). Finally, it is also important to note an element that opposes homelikeness and threatens resident health and wellbeing, which is the risk of clinicalization of care (Cowling, 2000; Cowling & Taliaferro, 2004). As clinicalization is defined as the de-emphasizing of healing and wholeness, and whereas homelike care environments are ideal for promoting healing (Collier et al, 2015, p. 698-700; Molony, 2010, p.292; Robinson et al, 2010), homelike care environment cannot also be highly clinicalized environments. Therefore, in order to produce an ideal therapeutic environment for healing, clinicalization must be balanced with the promotion of factors creating a sense of home.

Question two, identifying restrictions were imposed in LTC facilities in response to the pandemic, and how were these restrictions likely to impact residents' feelings of being at home, was answered through a comprehensive analysis of the relevant policy documents, primarily COVID-19 directives and public health orders. Those policies as most detrimental to creating a sense of home in long-term care can be grouped as follows: (i) the implementation of isolation wards and rooms, (ii) requirements for increased signage, masking, and screening stations, (iii) salon and dining room closures, cohorting requirements, gathering limits, visitation limits, and kitchen closures to residents, (iv) visitor restrictions, gathering limits, and isolation requirements, and (v) environmental services policies, such as not permitting unnecessary objects in isolation rooms and limiting the usage of objects to those that can be cleaned according to IPAC standards. These restrictions would have created frequent interruption to the daily routines of residents by staff uniformed in environmental services attire and PPE, and would have prevented activities requiring the sharing of materials or items, such as gardening tools, crafting tools, the folding of laundry, or the preparation of food. Further, the sanitization of areas frequented by residents may would have increased the degree of clincalization of resident lives through infection prevention and control practices, thereby further limiting the homelike atmosphere of the environment.

The likely impacts of these policies on long-term care residents' sense of being 'at home' and their health and wellbeing, was addressed through the considering the health impacts on the COVID-19 restrictions on residents of long-term care, based on what had previously been established by this project on how those restrictions limited the factors contributing to a sense of home, and how that sense of home impacts health outcomes. In order to prevent over clinicalizing care for residents and to meet the *Long-Term Care Facility Requirements*

commitment to a holistic approach to resident wellbeing that ensures meeting both social-psychological and physical needs, infection prevention and control decisions should better mitigate the negative, unintended effects, and justify their decisions as reasonably necessary, as is required by law (Government of Canada, 2023). This research suggests that by promoting key factors such as maintaining socialization, regular routines, engagement in meaningful activity, and autonomy in distraction free environments even under restrictions relating to disease outbreaks can optimize the health and wellbeing of residents. As a result, long-term care residents and their families may be better assured that care is truly being delivered in a manner to ensure residents are living well in a place they can call home, regardless of ever-present epidemiological concerns (Government of Nova Scotia, 2019, p.5).

This approach, however, requires a shift away from the long-standing prioritization of care that emphasizes physical needs over those relating to mental health and overall wellbeing. While ongoing issues relating to limited resources, including insufficiency of the beds, services, and facilities necessary for the specialized care required by residents, have led to a system that often cannot address all of a resident's multifaceted needs at once, this research has shown that such an approach can be detrimental to long-term resident health. Such a shift in care culture will require government recognition of long-term care as important because of the benefit it provides for citizens, rather than the associated economic risks and advantages. De-commodification of the long-term care system through the removal of a market-price value, even if that price is subsidized for individuals, is necessary. By exposing the details of how long-term care policies, even those that are implemented to protect the immediate physical health of residents, can impact overall health and wellbeing, long-term care experiences can be better understood and humanized. Recognition of the results of this research and those of other similar studies by those

legislating and providing care to residents can help to promote this de-commodification and emphasze the value of long-term care in improving the lives of Nova Scotians.

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Appendix A – Codeset (Primary, Secondary, Tertiary, and Definitions)

Codes	Type of Code	Definition
Physical Design Elements	Primary	These are physical design elements intended to create a home-like or less clinical atmosphere in long-term care
Private Rooms	Secondary	These are rooms in which a only single resident has a bed, with or without a shared bathroom
Privacy	Tertiary	This refers to privacy being facilitated through private rooms with the intention of improving a sense of home for residents
Limiting Distractions/Triggers	Secondary	These are efforts taken to limit or reduce distractions or triggers for residents
Cleanliness	Tertiary	This refers to the cleanliness of the long-term care facility when referenced with relation to limiting distractions or triggers
Low Ceiling Height	Tertiary	This refers to a lowered ceiling height with the intention of making the space feel more home-like and less institutional and reducing distractions and triggers
Lighting	Tertiary	This refers to lighting choices made with the intention of making the space feel more home-like and less institutional and reducing distractions and triggers
Colour of Walls and Floors	Tertiary	This refers to colour choices made with the intention of making the space feel more home-like and less institutional and reducing distractions and triggers
Hidden Medical Facilities	Tertiary	This refers to design elements such as the hiding of a nursing desk that are made with the intention of making the space feel more home-like and less institutional and reducing distractions and triggers

Codes	Type of Code	Definition
Daily Routine	Secondary	This refers to design choices or efforts made by long-term care staff to facilitate continuation of the familiar daily routine of residents
Structural Lay-Out	Tertiary	This refers to when the structural lay-out of a facility has been created with the intention of facilitating continuation of the familiar daily routine of residents
Cottage-Like Design	Tertiary	This refers to facilities with a cottage-like design that look more like a traditional single family home and less like an institution
Kitchen	Tertiary	This refers to kitchen designs which are open and friendly for residents, to aid in the facilitation of their familiar daily routines
Laundry Room	Tertiary	This refers to laundry room designs which are open and friendly for residents, to aid in the facilitation of their familiar daily routines
Office Space	Tertiary	This refers to office space designs which are open and friendly for residents, to aid in the facilitation of their familiar daily routines
Salon	Tertiary	This refers to the inclusion of a salon within care facilities, to aid in the facilitation of their familiar daily routines
Dining Room(s)	Tertiary	This refers to office space designs which are open and friendly for residents, to aid in the facilitation of their familiar daily routines, being more similar to a family dining room and avoiding institutional design
Elements of Care	Primary	This refers to certain elements incorporated into the daily care of residents to support health and wellbeing

Codes	Type of Code	Definition
Meaningful Activities	Secondary	This refers to activities facilitated by long-term care staff which allow residents the chance for meaningful participation and engagement
Familiar Routines	Tertiary	This refers to those activities which offer residents the chance to engage in familiar daily routines
Folding Laundry	Tertiary	This refers to folding laundry as an activity allowing for meaningful participation and engagement
Cooking	Tertiary	This refers to cooking as an activity allowing for meaningful participation and engagement
Gardening	Tertiary	This refers to gardening as an activity allowing for meaningful participation and engagement
Scrapbooking	Tertiary	This refers to scrapbooking as an activity allowing for meaningful participation and engagement
Social Engagement	Secondary	This refers to opportunities which allow residents the chance for meaningful social engagement
Pets/Domestic Animals	Tertiary	This refers to interactions with pets/domestic animals which allow residents the chance for meaningful social engagement
Resident – Resident Relationships	Tertiary	This refers to interactions with other residents which allow residents the chance for meaningful social engagement
Resident – Staff Relationships	Tertiary	This refers to interactions with staff which allow residents the chance for meaningful social engagement
Socio-Cultural Roles	Tertiary	This refers to interactions which allow residents to maintain or develop socio-cultural roles such as assisting in worship, which allow residents the chance for meaningful social engagement

Codes	Type of Code	Definition
Physical Objects	Primary	This refers to physical objects belonging to residents themselves, not to the facility or with the intention of being shared within it
Personal Objects	Secondary	This refers to personal objects belonging to residents
Presence of any Personal Object/Item	Tertiary	This refers to the mere presence of any personal object in at resident's room or space
Use of Personal Objects in Daily Routine	Tertiary	This refers to personal objects used to facilitate continuation of a resident's familiar daily routine
Personal Objects and Sociability	Tertiary	This refers to personal objects used to facilitate social engagement between a resident and others
Photos/Pictures	Secondary	This refers to photos or pictures belonging and available to a resident
Wardrobe Items/Accessories	Secondary	This refers to wardrobe items and accessories belonging and available to a resident
Handbag/Purse	Tertiary	This refers to a handbag/purse belonging and available to a resident
Jewelry	Tertiary	This refers to jewelry belonging and available to a resident
Clothing Item(s)	Tertiary	This refers to clothing items belonging and available to a resident

Codes	Type of Code	Definition
Reduction in Behavioural Symptoms	Primary	This refers to any reductions to Behavioural symptoms made through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Four "A's": Apathy, Anxiety, Agitation, and Aggression	Secondary	This refers to any of the four "A's" being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Reducing Distraction	Secondary	This refers distractions being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Preventing Startle	Secondary	This refers startles being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Nutrition	Secondary	This refers nutrition being improved through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Preventing Complications of Isolation: cardiovascular disease, obesity, stroke, anxiety, depression, interrupted sleep patterns and cognitive decline	Secondary	This refers isolation being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Maintaining Physical and Mental Skills and Dexterity	Secondary	This refers physical and mental dexterity being maintained through the incorporation of the physical design elements, elements of care, and personal objects mentioned above

Codes	Type of Code	Definition
Reducing Reliance on Anti-Psychotic Drugs	Primary	This refers to the use of anti-psychotic drugs being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Anti-Psychotic Medication	Secondary	This refers to the use of anti-psychotic medication being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Anti-Depressant(s)	Secondary	This refers to the use of anti-depressant drugs being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Sedative(s)	Secondary	This refers to the use of sedatives being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Medical Restraint(s)	Secondary	This refers to the use of medical restraints being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Chemical Restraint(s)	Secondary	This refers to the use of chemical restraints being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above

Codes	Type of Code	Definition
Mitigating Impact of Relocation	Primary	This refers to the impact of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above, or resident autonomy, informed decision making, on control
Mortality	Secondary	This refers to mortality as a result of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above, or resident autonomy, informed decision making, on control
Morbidity	Secondary	This refers to morbidity as a result of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above, or resident autonomy, informed decision making, on control
Falls	Secondary	This refers to falls as a result of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above, or resident autonomy, informed decision making, on control

Codes	Type of Code	Definition
Stress	Secondary	This refers to stress as a result of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above, or resident autonomy, informed decision making, on control
Depression	Secondary	This refers to depression as a result of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above, or resident autonomy, informed decision making, on control
Insomnia	Secondary	This refers to insomnia as a result of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Autonomy	Secondary	This refers to encouraging resident autonomy as a method of mitigating the impact of relocation
Informed Decision Making	Secondary	This refers to resident informed decision making as a method of mitigating the impact of relocation
Control	Secondary	This refers to encouraging resident control as a method of mitigating the impact of relocation
Lived Space	Secondary	This refers to the spaces in which residents conduct their daily lives
Meaningful Activities	Secondary	This refers to participation in meaningful activities as a method of mitigating the impact of relocation

Codes	Type of Code	Definition
Social Engagement	Secondary	This refers to social engagement as a method of mitigating the impact of relocation
Physical Design Elements	Primary	These are physical design elements intended to create a home-like or less clinical atmosphere in long-term care
Private Rooms	Secondary	These are rooms in which a only single resident has a bed, with or without a shared bathroom
Privacy	Tertiary	This refers to privacy being facilitated through private rooms with the intention of improving a sense of home for residents
Limiting Distractions/Triggers	Secondary	These are efforts taken to limit or reduce distractions or triggers for residents
Cleanliness	Tertiary	This refers to the cleanliness of the long-term care facility when referenced with relation to limiting distractions or triggers
Low Ceiling Height	Tertiary	This refers to a lowered ceiling height with the intention of making the space feel more home-like and less institutional and reducing distractions and triggers
Lighting	Tertiary	This refers to lighting choices made with the intention of making the space feel more home-like and less institutional and reducing distractions and triggers
Colour of Walls and Floors	Tertiary	This refers to colour choices made with the intention of making the space feel more home-like and less institutional and reducing distractions and triggers

Codes	Type of Code	Definition
Hidden Medical Facilities	Tertiary	This refers to design elements such as the hiding of a nursing desk that are made with the intention of making the space feel more home-like and less institutional and reducing distractions and triggers
Daily Routine	Secondary	This refers to design choices or efforts made by long-term care staff to facilitate continuation of the familiar daily routine of residents
Structural Lay-Out	Tertiary	This refers to when the structural lay-out of a facility has been created with the intention of facilitating continuation of the familiar daily routine of residents
Cottage-Like Design	Tertiary	This refers to facilities with a cottage-like design that look more like a traditional single family home and less like an institution
Kitchen	Tertiary	This refers to kitchen designs which are open and friendly for residents, to aid in the facilitation of their familiar daily routines
Laundry Room	Tertiary	This refers to laundry room designs which are open and friendly for residents, to aid in the facilitation of their familiar daily routines
Office Space	Tertiary	This refers to office space designs which are open and friendly for residents, to aid in the facilitation of their familiar daily routines

Codes	Type of Code	Definition
Salon	Tertiary	This refers to the inclusion of a salon within care facilities, to aid in the facilitation of their familiar daily routines
Dining Room(s)	Tertiary	This refers to office space designs which are open and friendly for residents, to aid in the facilitation of their familiar daily routines, being more similar to a family dining room and avoiding institutional design
Elements of Care	Primary	This refers to certain elements incorporated into the daily care of residents to support health and wellbeing
Meaningful Activities	Secondary	This refers to activities facilitated by long-term care staff which allow residents the chance for meaningful participation and engagement
Familiar Routines	Tertiary	This refers to those activities which offer residents the chance to engage in familiar daily routines
Folding Laundry	Tertiary	This refers to folding laundry as an activity allowing for meaningful participation and engagement
Cooking	Tertiary	This refers to cooking as an activity allowing for meaningful participation and engagement
Gardening	Tertiary	This refers to gardening as an activity allowing for meaningful participation and engagement
Scrapbooking	Tertiary	This refers to scrapbooking as an activity allowing for meaningful participation and engagement
Social Engagement	Secondary	This refers to opportunities which allow residents the chance for meaningful social engagement

Codes	Type of Code	Definition
Pets/Domestic Animals	Tertiary	This refers to interactions with pets/domestic animals which allow residents the chance for meaningful social engagement
Resident – Resident Relationships	Tertiary	This refers to interactions with other residents which allow residents the chance for meaningful social engagement
Resident – Staff Relationships	Tertiary	This refers to interactions with staff which allow residents the chance for meaningful social engagement
Socio-Cultural Roles	Tertiary	This refers to interactions which allow residents to maintain or develop socio-cultural roles such as assisting in worship, which allow residents the chance for meaningful social engagement
Physical Objects	Primary	This refers to physical objects belonging to residents themselves, not to the facility or with the intention of being shared within it
Personal Objects	Secondary	This refers to personal objects belonging to residents
Presence of any Personal Object/Item	Tertiary	This refers to the mere presence of any personal object in at resident's room or space
Use of Personal Objects in Daily Routine	Tertiary	This refers to personal objects used to facilitate continuation of a resident's familiar daily routine
Personal Objects and Sociability	Tertiary	This refers to personal objects used to facilitate social engagement between a resident and others
Photos/Pictures	Secondary	This refers to photos or pictures belonging and available to a resident
Wardrobe Items/Accessories	Secondary	This refers to wardrobe items and accessories belonging and available to a resident

Codes	Type of Code	Definition
Handbag/Purse	Tertiary	This refers to a handbag/purse belonging and available to a resident
Jewelry	Tertiary	This refers to jewelry belonging and available to a resident
Clothing Item(s)	Tertiary	This refers to clothing items belonging and available to a resident
Reduction in Behavioural Symptoms	Primary	This refers to any reductions to Behavioural symptoms made through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Four "A's": Apathy, Anxiety, Agitation, and Aggression	Secondary	This refers to any of the four "A's" being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Reducing Distraction	Secondary	This refers distractions being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Preventing Startle	Secondary	This refers startles being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Nutrition	Secondary	This refers nutrition being improved through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Preventing Complications of Isolation: cardiovascular disease, obesity, stroke, anxiety, depression, interrupted sleep patterns and cognitive decline	Secondary	This refers isolation being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above

Codes	Type of Code	Definition
Maintaining Physical and Mental Skills and Dexterity	Secondary	This refers physical and mental dexterity being maintained through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Reducing Reliance on Anti-Psychotic Drugs	Primary	This refers to the use of anti-psychotic drugs being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Anti-Psychotic Medication	Secondary	This refers to the use of anti-psychotic medication being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Codes	**Type of Code**	**Definition**
Anti-Depressant(s)	Secondary	This refers to the use of anti-depressant drugs being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Sedative(s)	Secondary	This refers to the use of sedatives being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Medical Restraint(s)	Secondary	This refers to the use of medical restraints being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Chemical Restraint(s)	Secondary	This refers to the use of chemical restraints being reduced through the incorporation of the physical design elements, elements of care, and personal objects mentioned above

Codes	Type of Code	Definition
Mitigating Impact of Relocation	Primary	This refers to the impact of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above, or resident autonomy, informed decision making, on control
Mortality	Secondary	This refers to mortality as a result of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above, or resident autonomy, informed decision making, on control
Morbidity	Secondary	This refers to morbidity as a result of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above, or resident autonomy, informed decision making, on control
Falls	Secondary	This refers to falls as a result of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above, or resident autonomy, informed decision making, on control
Stress	Secondary	This refers to stress as a result of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above, or resident autonomy, informed decision making, on control

Codes	Type of Code	Definition
Depression	Secondary	This refers to depression as a result of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above, or resident autonomy, informed decision making, on control
Insomnia	Secondary	This refers to insomnia as a result of relocation being mitigated through the incorporation of the physical design elements, elements of care, and personal objects mentioned above
Autonomy	Secondary	This refers to encouraging resident autonomy as a method of mitigating the impact of relocation
Informed Decision Making	Secondary	This refers to resident informed decision making as a method of mitigating the impact of relocation
Control	Secondary	This refers to encouraging resident control as a method of mitigating the impact of relocation
Lived Space	Secondary	This refers to the spaces in which residents conduct their daily lives
Meaningful Activities	Secondary	This refers to participation in meaningful activities as a method of mitigating the impact of relocation
Social Engagement	Secondary	This refers to social engagement as a method of mitigating the impact of relocation