Nursing Home Visiting Policy during COVID-19

Translated from the Dutch version: https://www.actiz.nl/nieuws/handreiking-bezoekregeling-verpleeghuizen-gereed

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1. Reading guide

In this handout, the measure to close nursing homes and small-scale housing in the care of the elderly for visits in the context of the coronavirus is highlighted from different perspectives. Here we outline the dilemmas that arise from this. As a guiding principle, in accordance with the quality framework, we apply that respect for freedom of choice, personal care, and well-being must be given the most severe possible weighting in the decision-making process on a visiting arrangement for nursing homes.

Based on the perspectives, we distinguish the following central dilemmas:

- Safety versus human dignity (from the resident)
- Safety versus human dignity (from the visitor; loved ones, family or legal representative)
- Safety versus pressure on the healthcare professional

This has led to eight principles:

Principle 1: A non-psychogeriatric resident is able to understand (after explanation) what the risk of infection entails and what consequences infection with the coronavirus would have for him or her. On the basis of the information itself, the resident is able to determine/weigh whether he or she is at risk of contamination (which is reduced by measures).

Principle 2: The choice of a resident to receive a visit should not be unreasonably at the expense of the safety of another resident (who experiences this as involuntary risk) or of the care professional.

Principle 3: The resident is not able to determine/weigh whether he or she wants to run the risk of infection (which is reduced by measures) voluntarily. The resident is assisted in the choice by (informed) relatives, in consultation with the care professional.

Principle 4: Visitors have insight into the risks and measures taken and decide (on the basis of this information) themselves, in consultation with the resident or care professional, whether they come. They have no say in the content and form of the organization's (visiting) policy. For example, the pressure to choose in the interest of the entire nursing home is not placed with the (individual) visitor.

Principle 5: The choice of the visitor to visit a resident should not be unreasonably at the expense of the safety of another resident (who experiences this as involuntary risk) or of healthcare professionals. If the visitor or a roommate of the visitor has (slight) complaints, the visitor does not come to the nursing home. The visitor also complies with all the agreements from the organization's visit policy.

Principle 6: In the regular care for a coronavirus suspected resident, the regular hygiene protocols are sufficient to be able to work safely.

Principle 7: If a resident is suspected of coronavirus infection, the care professional takes additional precautions, described by the RIVM, to protect him/herself.

Principle 8: If the healthcare professional falls into the risk category, he or she will consult with his or her supervisor to make a joint risk assessment, in order to fulfill his or her role in nursing home care.

The impetus for the visit protocol is attached as an annex to the handout. It should be stressed that we are thinking of phasing out the roll-out and intensity of the visiting protocol.

For the legibility of the handout, we use foot and endnotes. Footnotes, indicated by figures, refer to a decision, situation, or explain/supplement the text. Endnotes, indicated in letters, refer to the underlying sources.

2. Introduction

Since March 2020, the threat of the coronavirus has caused an unexpected crisis in the Netherlands. In uncertain circumstances, the government has taken tough measures to prevent the spread of the virus.

In the nursing home sector, the measure to close [1]nursing homes and small-scale housing in the care of the elderly from March 20th onwards will have a major impact on [2] visitors and others who are not necessary for basic care.[3]; a major impact. This closure measure is intended to protect vulnerable residents and healthcare professionals from [4] the coronavirus [5] and is in line with the Outbreak Management Team's (OMT) advice on limiting contacts and, in particular, restricting visits to vulnerable people. The measure also applies to volunteers and carers who experience complaints themselves or who fall into the group of vulnerable people. [6A] In practice, it appears that a large proportion of volunteers and carers fall into this group given their age.

The measure makes it not possible for family and friends of residents of nursing homes to visit for the time being, whereas this can be of great importance for the well-being of the resident. The protection measure thus attracts a huge change in nursing home residents, loved ones, and healthcare professionals. Of course, the organizations and their healthcare professionals do everything they can to keep residents and loved ones in touch with each other in other ways. However, there is no doubt that good initiatives such as (video) calling are not a substitute for direct contact.

The coronavirus is expected to affect life for a long time to come. It will also take a long time, according to the National Institute for Public Health and the Environment (RIVM), for a vaccine to become available. [B] Therefore, the urgency is high to think about an appropriate visiting arrangement. That is, a visiting arrangement that takes into account the threat of the coronavirus but puts the perspective of the quality of life of the resident at the heart of his or her last phase of life.

The nursing home is very specific to the sobering fact that this is a concern aimed at vulnerable residents who are no longer always able to control their own lives and are in their final stages of life. The credo of the medicine in earlier times with very limited possibilities for healing still fits perfectly with the task of care professionals in nursing homes: 'sometimes heal, often enlighten, always comfort'.[7] Healing and protecting against 'doom' is not central to this phase of life with other attendants, it is the special task for nursing home care to provide the best possible quality of life in that last phase. The National *Quality Framework*

1 Decision of the Ministerial Committee on Crisis Management, in coordination with Actiz and Zorghuisnl - associations in long-term care and client organisations and after consultation with the RIVM.

2 On 15 March, trade association Actiz itself decided to change the visit policy. The cabinet measure was extended on 21 April until 19 May.

3 Only in exceptional cases/under serious circumstances (and under certain conditions) may this policy be deviated (occasionally).

4 With care professionals, all nursing, caring, psychosocial, (para)medical and other disciplines working in nursing home care are referred to. By using this term, the distinction with volunteers is also visible.

5 Het coronavirus veroorzaakt covid-19.

6 Over-70s and those with underlying suffering.

7 According to Ambroise Paré (1510-1590): *'Medicine is sometimes healing, often relieving, always comforting'.*

for Nursing Home Care (more on this in the next paragraph) has written this meta-starting point more precisely.

> ***Remote contact is not a full-fledged alternative***
>
> For everyone, remote contact is not a full-fledged substitute for physical contact. There are additional barriers for residents of nursing homes and their loved ones. For example, video calling is not an option for everyone because loved ones don't always have the knowledge and/or equipment to be able to make video calls or because residents don't understand what's happening. Also, some residents are no longer able to express themselves orally so that real contact can only be of touch for them. Good initiatives such as behind-glass visits are therefore only a 'we do what we can' solution for the short term.

The quality of life for residents of nursing homes is now under severe pressure, as the National Umbrella of Client Councils (LOC) has reported emphatically. In order to be able to address the distressing situations resulting from the protection measures in a reasonable manner, the LOC recommends customization rather than a general rule.[C]

The National Nursing Home Care Organizations, united in a trade association Actiz, also found distressing situations due to the closure of nursing homes. They have therefore drawn up this handout with principles to arrive at the desired, practical and reasonable handling of the coronavirus in the specific context of nursing home visits. So that, if there is a possibility of enlargement, there is a clear reach nationally. The starting point of this handout is the quality of life of the resident.[8]

Moreover, the problems at the heart of this handout are not only true for nursing homes. Other (small-scale) forms of housing in the care of the elderly will also be closed to visitors on March 20th. According to CBS, 115,394 people were living in a nursing home in 2019.[9]

When looking at the care and well-being of residents, not only the healthcare professionals but also volunteers play an important role. These individuals contribute to optimizing the well-being of residents, for example by organizing and supporting group activities and giving personal attention. As mentioned earlier, volunteers often belong to the vulnerable target group themselves. A number of organizations have even (temporarily) completely terminated the use of volunteers as a result of the closure measure.

[8] From a healthcare ethical point of view, it is valuable to mention that 'family and loved ones are part of the identity of the patient' (van Nistelrooij, 2015). The relationships and maintenance of them are essential for being human.

[9] Different housing situations and compositions are conceivable (e.o. apartments, housing groups, rent and rehabilitation and repair departments in nursing homes). Tailor-made solutions are the starting point for any relaxation of visiting policies. The Protocol in the Annex may be guiding.

3. Quality Framework for Nursing Home Care

Since 2017, the *Nursing Home Care Quality Framework* [10] (from here: quality framework) forms the basis for the establishment of nursing home care. D The quality framework, in turn, is a further interpretation of the principles on quality described in the chapter 'control of the insured about his life' in the renewed long-term care law. The core is simple: the care provider respects a well-considered wish of the resident as to how the resident wishes to organize his life *unless* this is not reasonably possible.

The quality framework describes in more detail what is meant by good nursing home care and what clients and their loved ones can expect. In particular, these themes 'personal care and support' and 'living and well-being' form the basis for this handout.

The framework for **care and support** means the way in which the resident is the starting point in all areas of life in care and services. The resident is someone with a care and support need, but is above all a unique person with his own history, a future of his own and his own goals. Personal care and support take place within the relationship between the resident and his neighbor, the care professional, and the care organization. This is reflected in the following themes:

- *Compassion:* the resident experiences proximity, trust, attention and understanding and there is attention for family, loved ones and people who provide informal care
- *Being unique* is in line with the fact that dignity arises in connection with others. The client is seen as a person with a personal context that matters and with his own identity that comes into his own. Attention is also paid to the client's close family as part of his/her own life.
- *Autonomy*: Autonomy touches on the right to freedom and self-determination about one's own life and well-being: being free to make your own choices, to organize life itself and to be able to actually influence agreements that are made.

The theme of **well being** is about how the organization and caregivers in their care and services have an eye for optimal quality of life and the well-being of residents and their neighbors and are aimed at promoting and supporting them. This is reflected in the following themes:

- *Meaningful daily care*: attention and support of activities that make life worthwhile for the resident and allowing the resident to live life that suits his/her person as much as possible.
- Family participation and commitment of volunteers: relatives and other stakeholders from the social environment of the resident are given the space to participate in the care and support, are present in the department, and work together with the care professionals.

The Long-Term Care Act (see Article 8.1.1) states that the care provided must be supportive of the quality *of life* of the client. The resident is therefore given a personal arrangement that is tailored to his own needs. The healthcare provider is responsible for the quality of care and *support,* with the main building blocks: committed and skilled caregivers, a personal care plan and involvement of informal carers

[10] The quality framework was drawn up by the Quality Council of the Netherlands Health Institute and established in 2017 by the Board of Directors of the Care Institute. For the quality framework nursing home care, see the website of Zorginstituut Nederland.

Crucially, the resident as a human being is central. Self-possessing if possible and otherwise in consultation with his or her representative.

In this handout, the above themes from the quality framework and their further development are used as a guide. They are the basis of the dilemmas at the heart of this handout, while at the same time indicating the direction of solutions.

4. Perspectives and dilemmas

The measure to close nursing homes and small-scale housing in the care of the elderly for visits and others that are not necessary for basic care raises a few questions immediately, so the argument that this is for the 'good' of residents does not fit well with the right to self-determination from the qualification framework. It can even be argued that the measure goes against human rights E&F.

Naturally, residents and care institutions, like every individual and every organization, have a social responsibility to prevent the expansion of COVID-19 infections as much as possible. This also seems to be due to the idea behind the intelligent lock-down policy,[11] namely 'flatten the curve', the prevention of the over-search of hospital care. It is noted that in almost all cases a resident of a nursing home infected with the coronavirus is not transferred to a hospital to be cared for.[12]

The closure measure also has a downside for the nursing home specifically. The measure affects not only the residents but also the visitors and the care professional. [13]This raises a number of dilemmas that can be outlined from different perspectives. In this handout, we have three perspectives:

- the occupant of the nursing home
- the visitor of the resident[14]
- care professional.

Moreover, we distinguish in this handout the target groups residing in the nursing homes. Although we prefer to distinguish these target groups in terms of willability (since there is also such a thing as partial will) it has been chosen to maintain medical terminology in this handout, while distinguishing the black and white distinction between psychogeriatric clients and non-psychogeriatric clients. It should be noted that this distinction looks at whether or not he/she can make informed choices on this subject and can or cannot make well-considered choices.

This distinction is important because it affects the concepts of 'own direction' and the 'voluntary risk' (arising from concepts such as 'risk perception' and 'risk acceptance') and thus has an impact on the effects of the dilemmas.

We distinguish the following central dilemmas (which are inextricably linked):

- Safety versus human dignity (from the resident)
- Safety versus human dignity (from the visitor)
- Safety versus pressure on the healthcare professional[15]

[11] The intelligent lockdown is in the interest of (collective) safety and public health.
[12] Healthcare professionals who work in the nursing home and become infected can be admitted to hospital.
[13] This is mostly about family or friends, if the physical and/or psychological conditions of the nursing home resident had allowed it, would have liked to still be together (or live in the case of partners) with the nursing home resident.
[14] The visitor can also be a carer. The purpose of a carer's visit is broader than the goal of a regular visitor.
[15] This pressure affects the quality of care and concerns both physically and mentally taxing.

This handout denotes these dilemmas and gives insights and recommendations on how to deal with them. As a guiding principle, in accordance with the quality framework, we apply that respect for freedom of choice, personal care, and well-being must be given the most severe possible weighting in the decision-making process on a visiting arrangement for nursing homes.

We realize that the subject is emotionally fraught and there are no ready-made, simple solutions. However, we also know that when you ask society about dealing with risks, it is realistic and sober G . Based on this awareness and this trust in our residents, their representatives, and our healthcare professionals, this handout has been achieved in joint consultation, with these parties.

The following paragraphs further explain the perspectives and associated dilemmas. As a result, principles have been formulated. These principles are leading the way to the first step to the visit protocol, drawn up in the Annex to this handout.

5. The perspective of the non-psychogeriatric resident

Safety versus human dignity

In the quality framework, safety is also mentioned as one of the substantive themes. Safety involves risk awareness and risk reduction. Safety is a high priority, but it must be seen in balance with the other substantive themes in the quality framework, namely 'personal care and support' and 'well-being'. A devilish dilemma can arise when personal freedom and well-being face personal safety (from a medical perspective) and risks arise.

At present, the importance of safety and public health seems to be weighed more heavily by the government than the importance of well-being. Can we blame the government for this? As the saying goes *desperate times ask for desperate measures*. With limited knowledge, resources, and time, the government must decide on a radical intervention; a little too safe, rather than safe enough.

The (general) measure to close the nursing homes for visits is not without consequences. It should not be underestimated what effect 'something too safe' can have in this case. In order to protect residents, in their final stages of life, they are taken away from what many still live for: contact with their loved ones. An important condition for personal care and support is therefore under pressure.

Reasonable consideration of the measure is necessary, taking into consideration not only the collective interest but also the individual interest. An example of a risk where a different consideration is made is the risk of falling. Although the risk of falling is increased in the majority of residents in a nursing home, it is not the case that they are no longer allowed to get out of bed to reduce the risk of falling. In some ways, the fall risk is partially accepted with some [16]reasonable precautions (placing a walker in a fixed place next to the bed, using a fall protection mattress, etc.).

Risk perception and acceptance, voluntary and involuntary risks

Scientific studies have long pointed to the difference between risk perception and risk acceptance [H]. Risk perception is an estimate, namely an estimate of the 'danger' of a risk. Risk acceptance, on the other hand, is a trade-off: what are the pros and cons of the risk to me, and am I prepared to accept this risk, no matter how dangerous I find it? [I]

In addition, we distinguish voluntary risks from involuntary risks in this handout. Both are subject to risk perception. There are three criteria for being able to speak of voluntary risk:

1. the nature, extent, and probability of the risk are known (which gives people an action perspective and allows people to influence and make choices);
2. it has been (preferably made clear by the government) that you are at risk of this and
3. there are no disadvantages for others associated with it.

[16] We realize that the comparison does not go one-on-one, falling risk plays at an individual level while the risk of COVID-19 infection also affects others. We use this example as an illustration to outline the handling of risks in nursing homes.

> Involuntary risks are characterized by the collectivity of decisions, on which citizens depend but know little about them. Knowledge and information appear to be decisive for citizens to determine whether they are exposed to a voluntary or involuntary risk. G.

Is a willing resident himself able to make a decision about receiving visitors, knowing that if he or she can become infected, this could potentially lead to an early death?

To find an answer to this question, we use the concepts *of 'autonomy'* and *'being unique'* (translated here together as 'human dignity') and *'quality of life'* from the quality framework (see also paragraph 3). Human dignity is the basis and purpose of human rights. By extension, we argue that people are also free to opt for exposure to certain risks and thus accept a certain risk, provided that there are no disadvantages for others.

> ***Group activities such as meaningful time use***
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> For residents, (group) activities may be important for the quality of life. Due to the current measure (and the banning of many volunteers), many activities are practically no longer possible. The (group) activities can be a valuable interpretation and adequate incentive dose of the daily expenditure (and therefore the existence) of a resident who needs entitlement and 'coziness'. Also physically, stopping these activities has consequences, motor dwellers are deteriorating, with increasing dependence and loss of self-esteem as a possible result. Moreover, volunteers are often the bridge between the world of the resident and the outside world.

Having outlined this, we come to the conclusion that closing the nursing homes for visits that are not necessary for basic care and ending, among other things, group activities, is an extreme measure given the implications. The principle should be that healthcare professionals with the resident and his neighbor(s) weigh the safety risks against the quality of life.

Principle 1: A non-psychogeriatric resident is able to understand (after explanation of) what the risk of infection entails and what consequences infection with the coronavirus would have for him or her. On the basis of the information itself, the resident is able to determine/weigh whether he or she is at risk of contamination (which is reduced by measures).

Principle 2: The choice of a resident to receive a visit should not be unreasonably at the expense of the safety of another resident (who experiences this as involuntary risk) or of the care professional.

It is crucial that the choices and implementation of [17] the visit policy must be communicated clearly with the resident. After all, the resident himself has to make the trade-off between whether or not to receive visitors (taking into account the possible consequences and under the conditions in force). We expect the (non-psychogeriatric) resident to handle the risk and protection measures responsibly.[18]

[17] Think, for example, of a phased easing of current policies.
[18] Consequences of failure to comply with the nursing home guidelines are set out in the Annex outlining the start-up to the visit protocol.

6. The perspective of the psychogeriatric resident

Safety versus human dignity

For the psychogeriatric resident, the same reasoning applies in principle as for the non-psychogeriatric resident, with the exception that *principle 1* does not apply. In many cases, a psychogeriatric resident is unable to make independently informed choices regarding risks and the associated consequences. As a result, others, in this case, the care institutions, will have to make the risk assessment and choices for the resident. The care professional will have to discuss this with the resident's representative.

Although the psychogeriatric resident is unable to make an informed choice himself, the above dilemma also plays *on safety versus human dignity.* Given that psychogeriatric inhabitants have on average a short life expectancy, it can be argued that the emphasis on human dignity will also have to be very high for this group.

Because of the short time that residents and their loved ones can still spend together, but also because of the greater dependence on these residents, being unable to visit will have a major impact on the quality of the remaining life of the resident and his/her loved ones. By the way, not all psychogeriatric inhabitants (themselves) experience the lack. For a group of residents, closing the nursing home for visits can cause less unrest.

In consultation with the care professional, regarding the following principle, the choice will have to be made for the psychogeriatric resident whether or not he receives a visit. It is precisely the interaction between the care professional and the relatives of the residents that contributes to optimal care. Who better than someone who has known the (psychogeriatric) resident for years, to indicate in dialogue with the care professional what makes someone[19] happy?

Principle 3: The resident is not able to determine/weigh whether he or she wants to run the risk of infection (which is reduced by measures) voluntarily. The resident is assisted in the choice by (informed) relatives, in consultation with the care professional.

[19] Not yet considering that loved ones play an important role in horizontal supervision.

7. Visitor perspective

Safety versus human dignity

The measure also has drastic consequences for the neighbors of the resident. Partners, children, and other loved ones may miss their loved one, father, mother, or friend for a long time. Visiting someone from a platform or behind glass is not the same as being able to be together. Interviews also show that the contact between a visitor and resident prior to the measure in some cases consisted only of physical contact/touches. This contact now has become almost entirely impossible.

For visitors, there could be a moral dilemma when visiting or not. Do you choose with your mind (rationally and for safety reasons) or with your heart (emotion)? We will have to find a way through this dilemma by listening both to the arguments and the emotions.

On the one hand, there is the risk of infecting or becoming infected with someone (family/partner, but also the other inhabitants or someone in their own environment). This can be a well-founded reason not to visit the resident, as this can be a psychological burden for the visitor.

We know that people are aware that absolute safety does not[J] exist. If visitors are properly informed, they understand that there will always be a risk of contamination, whatever safety and hygiene measures will be taken. Even in countries with total lockdown, there is coronavirus based mortality in nursing homes. [K]

International perspective

Globally, countries are setting the course to contain the coronavirus crisis. Sweden, for example, has an accommodating policy, while other countries are opting for total lockdown. There are also different policies in relation to allowing visitors to nursing homes and institutions for the elderly. On the basis of a short[20] exploration, we see that Belgium had relaxed visitor policy for one day, which was reversed by the commotion that this caused, the United States of America is not yet pursuing a relaxed policy, nor does Germany allow visitors. France is the exception, as easing was announced on April 19th under very restrictive circumstances, with no more than two family members per resident allowed to visit.

Despite the real risk of infection, an (inner) debt question could start to play when the coronavirus would be brought in by the visitor. A conversation with members of a client council shows that it is plausible that this guilt will play out in visitors. "For my own wife, I would accept the risk, but not for others. Then I feel really guilty." The inevitable 'judgment' of the outside world is also perceived as pressure.

On the other hand, it cannot affect visitors who experience not being able to visit their loved one. In addition, as with the inhabitants, the visit can give a valuable interpretation of their loved one's existence for the visitor. Human dignity is therefore not only a point of attention for the resident but also from the point of view of the visitor. Moreover, family members may feel guilty by not being able to meet the perceived duty of care if they cannot visit, even if you could objectively argue that a resident does not consciously experience the on- or

[20] Enquiry via Planetree on 24 april.

absence of visits. The restrictive measures deprive them of the possibility of seeing the resident and playing a role in the final phase of their lives.

Based on the human dignity principle, nursing homes will have to return to visit under certain conditions and to a limited extent. Like the residents, visitors will have to deal with the risks and protection measures.

Principle 4: Visitors have insight into the risks and measures taken and decide (on the basis of this information) themselves, in consultation with the resident or care professional, whether they come. They do not have a say in the content and form of the organization's (visiting) policy. For example, the pressure to choose in the interest of the entire nursing home is not placed with the (individual) visitor.

The fact that visitors do not have a say in the visitor policy does not mean that no responsibility is expected of the visitor. The visitor will have to comply with the agreements that are made and have to deal with the visit plan consciously.

Principle 5: The choice of the visitor to visit a resident should not be unreasonably at the expense of the safety of another resident (who experiences this as involuntary risk) or of healthcare professionals. If the visitor or a roommate of the visitor has (slight) complaints, he does not come to the nursing home. The visitor also complies with all the agreements from the organization's visit policy.

It is crucial that new visiting policies need to be communicated clearly with the visitor.

8. The perspective of the healthcare professional

Safety versus the pressure on the healthcare professional

Closing the nursing homes for visits that are not necessary for basic care has a major impact on the work of healthcare professionals. The absence of volunteers and carers puts extra pressure on the shoulders of the care professional who must try to compensate for the extra quality of life that carers offer. The absence of visits also regularly leads to an increase in misunderstood behavior among psychogeriatric residents because rhythm/routine falls away and the absence of visitors may be difficult to explain.[21]

To relieve the care professional, it is therefore desirable, as soon as this is possible, to give volunteers and carers access to the nursing homes again, under appropriate conditions. The volunteers who are allowed back will, therefore, have to make a demonstrable contribution to the well-being of residents and/or reduce the workload of health care professionals.

However, an easing of the visit policy could also lead to new concerns for staff. In our conversations, the fear of coronavirus among healthcare professionals appeared to play a significant role. These are both concerns about their own safety and their own loved ones and about the concerns safety of residents.

If residents are not suspected of being infected with the coronavirus, the usual hygiene measures and personal protective equipment are sufficient to not be at a higher risk as a healthcare professional at work than elsewhere.

Additional personal protective equipment should be provided for the care of residents infected with the coronavirus. These must, of course, be sufficiently present, as should the possibility of testing care staff when there is concern that a care professional is infected. Moreover, in principle, visitors will no longer be possible.

It is very understandable that healthcare professionals also have concerns about the additional risk that visitors pose to residents. Moreover, under the current magnifying glass of media and politics, the dying of the most vulnerable residents - partly due to the consequences of coronavirus – is seen as a failure of nursing home care. The focus is on the quality of life of residents as always. Without any substantive need to compromise on the 'human side' of care by providing residents only with overly heavy personal protective equipment is undesirable from that point of view. Healthcare professionals will be fully supported by their board in this respect.

Healthcare professionals who fall into a risk category may experience even more worry about becoming infected with the coronavirus themselves. A healthcare professional who belongs to the risk category will have to discuss this with his or her supervisor. Together, a responsible role in the nursing home will have to be determined.

[21] In some cases, the opposite may also be the case: some residents experience less unrest due to the delight of visits.

Principle 6: In the regular care for a non-coronavirus suspect resident, the regular hygiene protocols are sufficient to be able to work safely.

Principle 7: In a resident suspected of a coronavirus infection, the care professional takes additional precautions, described by the RIVM, L to protect himself.

Principle 8: If the healthcare professional falls into the risk category, he or she will consult with his or her supervisor to make a joint risk assessment, to fulfill his or her role in nursing home care.

Clear communication on the implementation of the revision of the visiting policy, the considerations leading to this, and the concrete significance for the healthcare professional are of great importance. Through this communication, we create support and ensure that the healthcare professionals also implement the policy themselves.

Quite practically speaking, a phase-in is needed in the relaxation of the visiting policy because it will initially mean additional workload for the care professional, for example, extra guidance for residents, psychosocial support for visitors, and the coordination of the visit and activities of volunteers.

Annex: Incitement to Visit Protocol (v1.0))

For safety and organizational[22] reasons, the policy will have to be **phased** [23] in. An important principle is: *the choice of a resident (or close ones) to receive visitors should not unreasonably be at the expense of the safety of another resident (who experiences this as involuntary risk) or of the care professional.*

In order to protect (in a reasonable way) residents, the number of visitors will have to be limited. Taking into account these seven principles, the following guidelines for receiving visitors can be considered:[24]

1. There will not be too many different people, with the resident and/or the representative deciding who is visiting.
2. The nursing home determines when the visit takes place.
3. There will not be too many visitors at the same time per resident (up to 2 at a time) and per department/housing group (matching the facilities of the location)
4. A visit does not come too often (2 per week)
5. A visit does not go on for too long (up to 1 hour at a time))
6. The visitor has no COVID-19 related complaints (nor does his housemates) and complies with all hygiene and safety regulations.[25]
7. A temporary restriction on the visiting policy shall be put in place if there is a increase in COVID-19 contamination at the site

This protocol offers conditions for customization. It offers the possibility to allow (to a limited extent) a visit and is not a ready-made product that is suitable at any location. The point is that a nursing home must have the correct protective resources available [26] and that hygiene and safety measures are strictly observed.

With regard to the policy, different conditions apply to the resident, the visitor, the care professional, volunteers/carers, and the nursing home. All compositions of residents are conceivable.

[22] Including, for example, evaluating current work processesAnd the arrangement of the furniture in the living room or logistics processes with a supply.
[23] The visit protocol was drawn up on the basis of the knowledge of this moment. Based on new scientific insights, changes in society and a grip on the virus, choices can be made regarding further easing (more visits, more frequent visits, etc.) or tightening of visiting policies. The drafting of this protocol is an iterative process.
[24] In the version of 30 April these are still talking points.
[25] Especially for psychogeriatric residents, physical contact plays a big role during the visit. It can be considered to, if the visitor complies with all applicable regulations, to deal less stringently with the 'one and a half meter' rule.
[26] The presence of sufficient personal protective equipment for the professional, the availability of sufficient testing capacity for professionals and residents and the possibility of recording appointments around visits in the care file.

1. The resident:

Non-psychogeriatric:

- Has independently made the choice whether he or she wishes to receive a visit. This is laid down in the resident's care plan. The contact person has been informed in writing.

- If possible, he or she will receive the visit in their own room and he or she and the visitor will also remain here. If the resident does not have his own room, during the visit, the resident and the visit can remain in a designated area.

Psychogeriatric:

- The choice of the visit was made in consultation with the representative and the care professional. This is laid down in the care plan.

- The representative discusses the choices regarding the visit with family members and other loved ones. In addition, this information is made available in writing, so that it can be shared with family members and other loved ones.

- If possible, he or she will receive the visit in their own room and he or she and the visit will also remain here. If the resident does not have his own room, during the visit, the resident and the visit can remain in a designated area.

2. The visitor:

- Stays at home if they/someone in their household has (mild) symptoms of the disease.

- Has signed up for a visit through the registration[27] procedure.

- Can identify himself and is included as a visitor in the care life plan.

- Has gone through the *health checklist's* prior to each visit and can answer all questions with 'no'.

- Applies hand disinfection upon entering the nursing home.

- Knows the guidelines of the RIVM and follows them.

- Is instructed about the visit protocol by the care professional and follows the instructions of the care professional at all times.

[27] This is necessary to plan the visit.

- Keeps a meter and a half/six feet away from all healthcare professionals and other attendees.

- Comes only for visiting the resident, questions to the care professional are asked by phone or by mail.

- Goes from the entrance of the nursing home directly to the room of the resident to visit or the space intended for the visit. It is not possible to use the living room where other residents are staying. The visitor remains in the room of the resident to visit or in the room intended for the visit and leaves the nursing home immediately after the visit.

- Bringing gifts/presents is permitted, excluding pets or drinks.

3. The care professional:[28]

- Knows the RIVM guidelines and follows them, both privately and in the working environment.

- Follows the instructions of the healthcare institution on how to deal with COVID-19 related complaints.

- Strictly applies the established and published working instructions regarding the use of personal protective equipment.

- Instructs visitor and volunteer according to a fixed instruction.[29]

4. The volunteer/carer:

- Knows the guidelines of the RIVM and follows them.

- Does not come to the nursing home if they/someone in their household has (mild) symptoms of the disease.

- Is instructed by the care professional/ volunteer coordinator and follows the instructions of the care professional at all times.

- Only comes on request and/or in consultation with the care professional.

- Follows the guidelines as stated among visitors.

[28] Other persons working in the nursing home should also comply with rivm guidelines.
[29] This is an instruction based on the visit protocol prepared for it. This instruction is clear and simple.

6. The nursing: home (procedures):

- The nursing home organizes that the residents, contacts (family members), and care professionals are informed about the risks. The nursing home takes into account the communication with the background and (on)possibilities of the recipient.

- The nursing home communicates transparently about the infections and subsequent measures.

- The nursing home provides a schedule for visits. This requires tight direction.

- Depending on the housing situation created, the group of residents is seen and treated as a household, in accordance with the definition of the RIVM.

- In the case of (or suspicion of) contamination of a resident, the resident is placed in temporary isolation and treated in accordance with the appropriate procedure. The care institution decides on a temporary reduction in the visiting policy taking into account the specific situation of the residential group/location/department and the course of the infection.

- The nursing home enables the care professional to work according to the working instructions and with personal protective equipment and disinfection material.

- The nursing home ensures that visitors clean their hands properly upon entry and that visitors can keep a meter and a half away from others inside the nursing home.

- The residents who want to receive visitors must have their own room or space. If this is not the case, there will have to be a specially equipped and lockable meeting room. This meeting room shall be cleaned at the end of each visit in accordance with the working instructions applicable to that end.

- The nursing home makes sufficient testing capacity available to both care staff and residents.

7. Cases of exception

- If there is a compound/group housing situation, other conditions may be made to visit.

- Exceptions can be made to the above principles for visiting terminally ill residents.

Endnotes

[A] State Government (2020, 19 March). Chamber letter on tightening visit to nursing homes linked to COVID-19.
[B] RIVM (z.j.). Vragen & antwoorden nieuw coronavirus (COVID - 19). Consulted on 30 April 2020 via https://www.rivm.nl/
[C] NOS (2020, 21 April) Client councils: relaxing visiting arrangements in nursing homes where possible.
[D] Zorginstituut Netherlands (2017). Quality framework nursing home care. Learn and improve together. Consulted on 30 April 2020 via https://www.zorginstituutnederland.nl/.
[E] For example, Article 3 and 13 of the Universal Declaration of Human Rights.
[F] For example, Article 8.1 of the European Convention on Human Rights.
[G] Bemer, E., Mulder, S. Verhue, D. (2012). *Citizens on Risks and Responsibilities*. Amsterdam: TNS Nipo.
[H] Van Tol, J., Helsloot, I., & Veld, M. (2015). *Hand-to-hand balancing administrative ly with risks and responsibilities.* The Hague: Ministry of The Interior and Kingdom Relations
[I] Slovic, P. (1987). Perception of risk. Science, 236(4799), 280-285.
[J] Ministry of The Interior and Kingdom Relationships (2014). *Kennisdocument: Burgers about risks and incidents.* The Hague.
[K] Frijters, S. & Van Uffelen, X.Volkskrant, 16 april 2020). Half of the coronal mortality rate in Europe takes place in nursing homes.

[L] RIVM (z.j.). Principles PBM outside the hospital Consulted on 5 May 2020 via https://lci.rivm.nl/covid-19/PBMbuitenziekenhuis