THE GLOBAL AGEING NETWORK

ELDER CARE PROVIDERS & COVID-19

Cross-Cultural Perspectives

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Global Ageing Network

The Global Ageing Network (GAN) is an international network of leaders in ageing services businesses, researchers, and advocates spanning about 60 countries. Over the last 30 years, GAN members have been committed to building connections, sharing knowledge, and learning from one another in our collective pursuit to make the world a better place to grow old.

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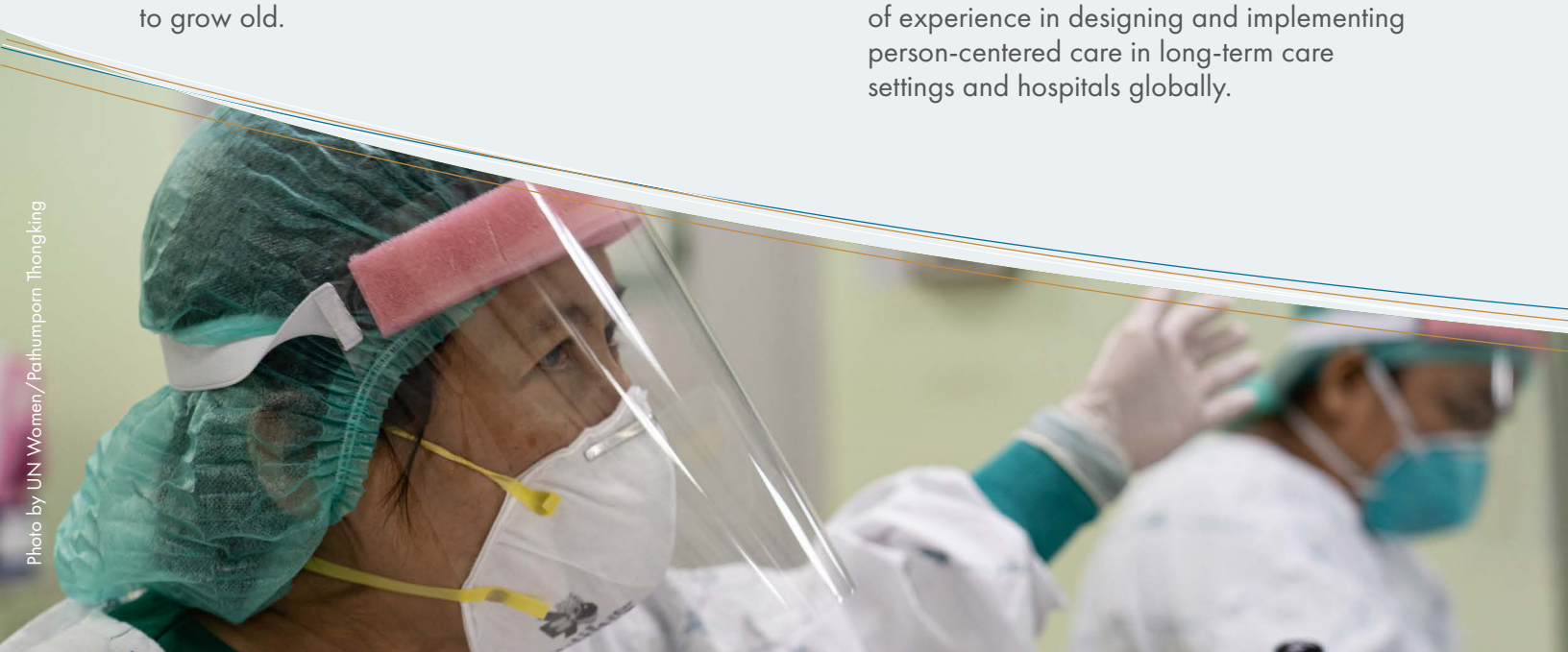
Dr. Emi Kiyota is the founder and director of Ibasho, an organization that facilitates the co-creation with elders of socially integrated, sustainable communities that value their elders. An environmental gerontologist and organizational culture change specialist, Dr. Kiyota is a consul-tant with over 20 years of experience in designing and implementing person-centered care in long-term care settings and hospitals globally.



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Foreword

The coronavirus pandemic has challenged health and long-term care systems across the globe. COVID-19 clearly does not respect boundaries of any kind. It does not stop at borders. It will not disappear after a predetermined time period. And it does not affect every individual in the same way. We have learned the hard way that the virus disproportionately impacts older adults, who are most susceptible to infection and, when infected, at greatest risk for serious illness and death.

Organizations that provide care, services, and supports to older adults have been on the front lines of fighting COVID-19, working tirelessly to keep residents, clients, and staff safe. More often than not, these providers have carried out this important mission without adequate resources, personal protective equipment (PPE), testing, or staff. They have largely been left to "figure it out" on their own.

Our global network of providers has never been more important than it is today. We support each other by sharing our solutions, strategies, and experiences. More than ever, we value our solidarity around common challenges and the opportunity for global learning that this solidarity provides. The more we can expand our global network and learn from one another, the greater will be our ability to address issues of equity—in care practices, prevention, treatment, and access to information.

This report is a summary of interviews conducted with providers and other stakeholders in 11 countries. These individuals graciously shared how they experienced the global pandemic from February through December 2020. While the insights shared here don't address the introduction of COVID-19 vaccines, which occurred after the interviews took place, they do address a range of other issues and challenges that providers encountered.

The following pages serve as a chronicle of the 2020 provider experience and offer some lessons and observations for our path forward. This report should cause us to consider deeply how we care for and support people in their later years—individuals who have played an integral role in building the societies we now enjoy.

Katie Smith Sloan, Executive Director
Global Ageing Network

Introduction

Elder care providers across the globe are experiencing unprecedented challenges due to the COVID-19 pandemic. They are stretched to capacity as they work to protect residents and staff members from this highly infectious virus while continuing to meet residents' daily care needs.

Elder care settings are especially vulnerable because high levels of frailty make residents more susceptible to severe COVID-19 infection, while close quarters and shared spaces make it difficult to prevent the virus from spreading. The fact that elder care is the sector hardest hit by the pandemic has been reported in various parts of the world, yet the full picture of COVID-19 infections and deaths in elder care settings is not clear. As of this writing in early 2021, COVID-19 is still spreading, and few countries have reliable data tracking the number of cases in their elder care settings.

Within the elder care sector, there has been limited global collaboration and little exchange of the knowledge that elder care providers gained on the front lines of the pandemic. This report examines how elder care providers in 11 countries responded to the challenges posed by COVID-19 in residential settings such as nursing homes or group homes. Their insights have the potential to help all providers around the world become better prepared for future health crises.

The coronavirus pandemic shed light on inequities among elder care providers in different parts of the world. These inequities include the financial resources needed, but not always available, to tackle the coronavirus and access needed resources, including medical care, workforce, training and education, testing, and technology. The pandemic also revealed how unprepared elder care systems were to respond promptly to challenges that require global coordination. The shortage of personal protective equipment (PPE) is a good example of this lack of preparedness.

As the COVID-19 crisis developed, providers and policy makers faced urgent questions about how to keep the coronavirus out of care settings, identify infections as early as possible, and prevent spread of the virus. To respond to these urgent challenges, providers implemented in-service staff training and education, changed their staffing patterns, or added hand-washing and screening stations to protect residents and staff.

Some new practices, while perhaps needed to save lives, seriously eroded quality of life for residents and clients. For example, most providers prohibited family and friends from visiting their loved ones. In the early days of the pandemic, residents were asked to stay in their own rooms for weeks at a time, putting them at great risk for social isolation and loneliness.

As providers and their frontline staff accumulate knowledge based on scientific findings and their own experience, strategies can be adjusted to integrate lessons learned during the pandemic. For example, what activities were stopped that we should not restart? What may have been paused that should start again, but perhaps differently? Which new strategies worked? Which did not?

This report focuses on the following 5 objectives:

1. Understand whether existing emergency and infection control plans were effective.
2. Learn how elder care providers protected their residents from COVID-19 by managing workforce issues, changing visitation protocols, testing and screening, communicating with health authorities, and changing the physical environment.
3. Understand how elder care providers perceive the effectiveness of their countries' policies and guidelines.
4. Identify key issues related to operations and workforce during a global pandemic.
5. Explore innovative solutions and strategies for managing the spread of infection while maintaining quality of life for residents.

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The report is divided into 3 sections:

- Methodology,
- Findings, and
- Lessons Learned.

The information presented here is not meant to represent the perspective of individual countries or their policy makers. Rather, it is designed only to share the experiences of elder care providers during the COVID-19 pandemic.

Methodology

Information included in this report comes from academics, policy makers, executive directors of elder care associations, and chief executive officers and chief operating officers of elder care organizations in 11 countries. The research took place between September 2020 and November 2020.

Data Collection

Due to geographical distances and language limitations, data were collected remotely by video conference and email communications. A semi-structured interview (Appendix A) was employed to allow participants to provide details about their experiences and insights, and to shed light on how providers ensured infection control and how they perceived the effectiveness of guidelines and policy support during the pandemic.

One researcher conducted all the interviews, which each lasted approximately 60-to-90 minutes. During the video conferences, the researcher took written notes, recorded the interviews with the interviewees' permission, and later transcribed the recordings. The researcher obtained information through email communications from respondents who preferred to communicate in writing because of language limitations or scheduling difficulties.

The information collected through interviews is current as of the date the interviews were conducted. The situation and programs of the organizations, as well as government policies, may have changed in the interim.

Participants

Participants were identified through connections with the Global Ageing Network and the Atlantic Fellows Program in Oxford, England. Senior managers in selected organizations were contacted by members of the Global Ageing Network and asked whether they would like to participate in a video conference interview with a researcher. The interview guide (Appendix A) was provided prior to the conference call. Sixteen participants completed semi-structured interviews and 3 participants responded to interview questions by email.

Data Analysis

Data were analyzed using the grounded theory approach to find emerging themes and key learnings. Contents from interview transcripts and researcher's notes were used to learn about provider experiences involving infection control preparedness, immediate responses to the pandemic, and policy perspectives. The researcher created an analytical matrix chart (Appendix B) to compare similarities and differences among the 11 countries. Four members of the project team analyzed the data and chart. Participants also reviewed the chart to ensure accuracy.

TABLE 1
Participant Information (n=19)

Country	Features of Elder Care Organizations
Argentina	26 residents in 1 care setting
Australia	2,400 residents in 34 care settings 153 residents in 2 care settings
Canada	2,500 residents in 19 care settings 287 residents in 4 care settings 323 residents in 1 care settings
Japan	300 residents in 15 care settings 2,500 residents in 49 care settings
Mexico	9 residents in 1 care setting 21 residents in 1 care setting 16 residents in 1 care setting
The Netherlands	165 residents in 1 care setting 1,103 residents in 14 care setting
Nigeria	5 residents in 1 care setting
Singapore	250 residents in 1 care setting 150 residents in 1 care setting
South Africa	1,133 residents in 13 care settings
Spain	1,800 residents in 18 care settings
The United Kingdom	662 residents in 7 care settings

Supplemental Information

The researcher interviewed policy makers, association officers, and academics to understand the policy background of each country. This information helped inform the data analysis.

Findings

Findings from interviews and content analysis are organized by 3 themes: Emergency and Infection Control Plans, Immediate Response, and Policies and Guidelines Relating to COVID-19.

The Immediate Response theme is further divided into 5 sub-themes: Workforce Issues, Visitation Protocols, Testing, Communication with Health Authorities, and the Physical Environment.

Similarities and differences among the various responses and experiences are discussed in this section, along with unique approaches employed by providers to meet pandemic-related challenges.

THEME 1: EMERGENCY AND INFECTION CONTROL PLANS

Emergency Preparedness: Most of the providers had their own emergency preparedness plans for major disasters, such as fire, hurricanes, earthquakes, and floods. Some providers even included pandemics in their emergency preparedness plans. Having an emergency preparedness plan was a national requirement for elder care providers in many countries, but voluntary in other countries like Spain and Mexico. In addition to the emergency preparedness plan, providers in Canada and Japan had dedicated teams or committees within their organizations that were charged with responding to emergencies and disasters.

Infection Control: Providers in all 11 countries had an infection control plan in place before the coronavirus pandemic began. Some providers prepared only for typical seasonal infections such as influenza while others, including the United Kingdom (UK) and Spain, had carried out pandemic planning. None of these pandemic-related plans and strategies were adequate to help providers prepare properly for the COVID-19 outbreak, due to the virus's high infection rate, the possibility of asymptomatic infection, the many early unknowns about COVID-19's progression and treatment, and other unusual features of the virus that are still coming to light.

Singapore and Japan have always emphasized the importance of including regular drills by all staff members in infection control plans. This may be attributed to the fact that Singapore's experience with severe acute respiratory syndrome (SARS) and Japan's frequent natural disasters helped these countries understand the need to train staff members in a strict manner.

Because so little was initially known about the coronavirus, it was crucial, especially early in the pandemic, for providers to find reliable information about infection control. Providers

in Australia and Canada made sure to integrate new knowledge about the virus into existing infection control plans as soon as that knowledge became available.

The Singapore government streamlined its communication channels so only 1 ministry, rather than 2, would release pandemic-related information. This approach was taken as a way to eliminate the possibility of sending mixed messages and to make it easier for providers to find the information they needed. Japan already had just 1 ministry that released updates on infection control and pandemic plans. Providers found it helpful to have a single source for updating infection control information. Some providers in the Netherlands, Argentina, and Canada reported benefitting from their geography, which gave them time to learn from the experience of other regions where the virus arrived first.

In Their Own Words:
Infection Control

We went through SARS in 2003, which was enough of a major outbreak at that point in time, but [our infection control plan] wasn't even close to managing this situation. We had updated it over time, but it wasn't effective enough at all. It's very robust now, when compared to what it was when we first began.

— Provider in Canada

There was so much unknown about COVID that in the beginning, every day we had to make our protocol better. It was searching for answers and not exactly knowing where to find them. So, that made it quite difficult in April and May.

— Provider in the Netherlands

THEME 2: IMMEDIATE RESPONSE

Workforce Issues

Education and Training: All the providers interviewed for this report offered in-service training about COVID-19 for their staff members. These trainings were developed by national, city, and local government employees; infection control experts; and internal teams. Education was delivered in person and online so staff members could access the trainings from the safety of their own homes. In countries where elder care policy is well established, educational materials were developed by national and/or local governments. In countries with a less-established elder care policy infrastructure—such as Argentina, Mexico, South Africa, and Nigeria—trainings were developed and organized by providers, doctors, and other clinical staff because there were no government training programs.

In-service education had a strong focus on infection control, including protocols for using PPE. Emotional health was addressed in a limited manner. Language limitations for

In Their Own Words:
Education and Training

All the staff members were given training around infection control. In addition, it was training on the virus itself. That, I think... was information overload, everyone putting out information around COVID-19. We had to filter through the information and say, 'Okay, what's relevant within our South African context, and how do we use that so that the information was useful?'

— *Provider in South Africa*

In Their Own Words:
Support for Staff Members

We gave (out) personal protective equipment for staff to use outside the organization, and provided mental health support.

— *Provider in Argentina*

(We provided) financial support that allows staff to stay in the building, including meals, beds, blankets, mattresses. We converted our communal spaces into living areas for our staff.

— *Provider in South Africa*

foreign-born care workers was a challenge for some countries, including Singapore and Canada. Providers tried to overcome these limitations by encouraging peers from the same country to help their colleagues understand the new materials.

Securing the financial resources needed to cover training time for all staff members was a challenge. Some providers addressed this challenge by providing training and education through e-learning and social networking platforms such as Facebook.

Support for Staff Members: Staff members received 3 types of pandemic-related support: financial support, emotional support, and recognition. Some supports were funded by the national government and others by the organizations where staff members worked.

The governments of Singapore and Japan distributed bonuses to all elder care workers. Providers in the Netherlands, Australia, and the UK received financial support from their governments to cover paid leave due to COVID-19. However, providers in other countries needed to cover salaries for staff members who were quarantined. This was especially challenging for providers in low- and middle-income countries. These providers supported quarantined staff members by reassuring them that their jobs were secure, and by providing them with housing, meals, and PPE.

Providers devised creative ways to support their staff members. For example, a provider in Australia offered childcare support, hotels for staff members, and emergency funds for staff and their families. Providers in the UK, Canada, Spain, the Netherlands, and Singapore supplied mental health support.

Loss of Staff: Most providers lost staff members due to 1 of 3 reasons:

1. Staff on sick leave due to having the virus.
2. Staff leaving out of concern about getting infected.
3. Government requirements, such as single-site directives, which required care staff to work in only 1 elder care setting.

Some providers filled empty positions by reassigning caregivers from other parts of the organization. Other providers hired new staff members through agencies, collaborations with local colleges, social media and websites, or word of mouth.

Providers in Mexico, Japan, South Africa, and the Netherlands reported having no turnover due to COVID-19. Providers in Argentina, Singapore, and Nigeria reported losing a few staff members who were afraid of getting infected on the job. Providers in the UK and Canada said that they lost some new employees during the pandemic because it was difficult for those employees to settle into different ways of working.

Providers in Australia, Canada, and Spain lost many staff members due to infections and single-site directives, and took organized action to hire staff to replace them. Providers in Canada and the Netherlands had success recruiting college students. Low- and middle-income countries experienced less turnover, since staff members and their families were more dependent on the salary from the care setting. Retaining and recruiting staff members seemed to be influenced by job satisfaction, organizational culture, and the work environment. Staff members in the UK, the Netherlands, and Japan had high satisfaction levels and were proud of their work. This could also be related to the culture and environment of their workplace.

In Their Own Words:
Loss of Staff

> Everybody stayed. ... It's difficult because here, many persons get fired from their work. They have no incomes. We do diminish their shifts, but we didn't fire any of the staff because we care about their sons and daughters, because they were single mom(s). If we fire, we think that they will be suffering a lot, so we decide to afford that.
>
> — *Provider in Mexico*

In Their Own Words:
Visiting Practices

With visitors, we put restrictions in and said that we wanted them to limit their time to 2 hours a day. Some other places put in bans—they banned all visitors visiting aged care. I personally had a problem with that. I think people were more likely to die of loneliness and depression than they were of COVID, and if we stopped people visiting, then that would be a big issue.

— Provider in Australia

In Their Own Words:
Communicating with Families

We are very lucky that in our home... we have in-house students, meaning that every floor has its own students who live among the elderly for free and then, in return, they are good neighbors. So, students made the tablets for the people fit to communicate with Skype or with video telephoning.

— Provider in the Netherlands

Visitation Protocols

Current Visitation Practices: Most of the providers implemented a complete lockdown in the beginning of the pandemic, allowing no visits. Many providers closed their buildings to visitors even before their governments issued directives ordering them to do so. However, all the providers raised concerns about social isolation among residents due to visitation restrictions.

Providers are eager to develop a creative system that allows for safe visits in the future. As of the time of the interviews, all but the Argentinian and Mexican organizations were allowing visits again, although those visits were subject to strict procedures and protocols, including:

- Requiring advance registration.
- Limiting the time of each visit.
- Restricting the number of visitors.
- Requiring visits to take place outdoors or in designated locations.
- Requiring all parties to wear masks.
- Screening visitors for COVID-19 upon arrival.

Providers in Japan and Singapore accommodated visits, with careful screening, even early in the pandemic, since community transmission rates were low and infection control was strictly enforced.

Communicating with Family Members: Finding new ways for both residents and providers to maintain regular communication with residents' family members was crucial during the pandemic. Providers used various communication methods, from low-tech

options like letters and phone calls to high-tech options like computers, tablets, and smart phones. Organizations sent updates to families more frequently at the beginning of the lockdown, and reduced updates as time passed.

Staff members helped elders use phones or tablets to connect with their loved ones through voice calls, video calls, social media messages and texts, or emails that were often sent with photos attached. Because technology literacy was not high among the elders, an Australian provider coordinated a volunteer group to help residents use available technologies. A Dutch provider mobilized its live-in students to help elders connect using technologies.

The pandemic revealed a technology disparity between industrialized countries and low- and middle-income countries. Technology equipment and broadband connections were more accessible in more affluent countries than in low- and moderate-income countries where providers had to fund their own technology. Technology literacy was more widespread in affluent countries.

Testing

All providers developed a COVID-19 screening system for residents and staff, although the methods varied widely depending on the country's level of response. While testing was available in most of the countries, few governments subsidized the cost of that testing, which created a financial burden for providers. Testing also created more work for staff members, who had to coordinate with government agencies to access test kits and report results. Obtaining and paying for tests was especially challenging for providers in low- and middle-income countries.

The UK provider offered weekly polymerase chain reaction (PCR) tests for residents and twice-weekly PCR testing for staff, and the lateral flow device (LFD) rapid antigen tests for all visitors. Other testing protocols varied by country:

- Providers in Argentina and Canada tested staff members every 10-14 days.
- Providers in Japan, South Africa, the Netherlands, and Spain offered daily screenings for residents and staff and tested only when individuals showed symptoms.
- New residents were tested in Mexico and Singapore.

In Their Own Words: Testing

We test every 28 days for residents and every 7 days for staff, unless there was 2 or more within a household. Then we would test everybody, and public health are now stepping in to do some of that as well.

— Provider in the UK

Yes, residents are screened. Residents are asked questions directed at picking up symptoms of COVID-19. Testing is not being done for both residents and staff due to the short supply in Benin City.

— Provider in Nigeria

- The Australian government conducted tests for both residents and staff members.
- Singapore tested all residents and staff members in elder care settings.
- The Nigerian provider was unable to test staff or residents due to a shortage of tests.
- Providers in Mexico could not test since only private-pay tests were available and the cost of those tests was too high.

In Their Own Words:
Personal Protective Equipment

PPE were available but they became 3–4 times more expensive. However, the price gaps were covered by the national government.

— *Provider in Japan*

Most of our PPE was made by ourselves, people from the community. The gowns were made from rubbish bags. We start buying them worldwide. For example, we bought a lot from a lorry that had to come from Germany, and the German government said that PPE was not allowed to go outside Germany. We bought another batch that came from China, and... the United States paid 3 times what we had paid, and they gave it to the United States. And it was like a fight, so we started to be creative, and to make them ourselves.

— *Provider in Spain*

Personal Protective Equipment

Most of the providers experienced serious PPE shortages in March, April, and May because their countries did not plan for a scenario in which the pandemic would create a global PPE demand that supply chains could not meet. There were 5 main challenges related to PPE:

1. A shortage of stock in reserve.
2. An inability to purchase PPE in time.
3. Quality control.
4. Lack of coordination through the public sector.
5. Inflated prices.

Providers commonly responded to PPE shortages by reusing equipment that was intended only for 1-time use. Most of the providers required staff to reuse N95 masks several times because shortages of these masks were the most severe. Providers in Mexico and the Netherlands reported that they bought only non-disposable gowns and washed or mended them so they could be reused.

Government coordination was the key factor in a provider's ability to secure PPE. The national government stepped in to coordinate supplies for elder care providers in Canada, Australia, and the UK. Providers in Japan and Singapore did not experience serious PPE shortages throughout the pandemic due to their governments' coordinated efforts to reserve and acquire PPE.

Providers in Argentina, Mexico, and South Africa had to figure out how to acquire PPE without help from the public sector. These providers ordered PPE through websites

offering products at inflated prices. Providers in these countries also experienced challenges in ensuring the quality of PPE, because there was no quality control system in place.

Communication with Health Authorities

Reporting Infections: Most providers reported infections to a city agency, local public health department, or national registration system. Providers in Mexico did not have any responsibility to report their infection status, since there is no government agency that oversees elder care settings.

Reliable Resources: As COVID-19 surged early on, knowledge and advice related to the virus was constantly evolving. With information pouring in from various sources, it was often difficult for providers to determine which information sources were reliable and which recommendations should be adopted.

Many providers searched for reliable information within their own countries, especially from local public health departments. Providers in the Netherlands, Singapore, and South Africa looked for information at the national level. Providers in Australia, Canada, the UK, Spain, and Japan relied on information and updates issued through regional or local offices. Providers in low- and middle-income countries generally sought information from their personal connections and from overseas websites. For example, a group of Mexican doctors used information from the UK, Spain, and the United States to develop guidelines for providers.

In Their Own Words:
Communication with Health Authorities

If there's a crisis, a good structure helps immediately, especially for communication, for working together, for helping each other.

— Provider in the Netherlands

Physical Environment

During early COVID-19 lockdowns, organizations scrambled to change their physical environments to protect their residents from infection. Common changes included:

1. Assigning a designated elevator for certain areas of buildings in order to reduce contact with residents from other areas.
2. Adding hand-washing stations.
3. Adding a staff break room to separate staff members during breaks and avoid cross-contamination among different staff teams.
4. Moving furniture or rearranging dining spaces to facilitate social distancing.
5. Modifying or adding signage about pandemic protocols.
6. Paying careful attention to ventilation by regularly opening windows.

In Their Own Words:
Physical Environment

I think that ventilated areas, with adequate social distance, strict control of workers who circulate out of the institution, (and) using the complete PPE permanently, has been effective to prevent new outbreaks.

— *Provider in Argentina*

Once residents were diagnosed with COVID-19, providers isolated them in order to prevent the virus from spreading. In some countries, COVID-19 units were required by the government, but the establishment of these special units was voluntary in most countries. Some providers created COVID-19 units by setting aside 1 or 2 rooms or certain parts of buildings to house residents who tested positive for the virus. Other providers with small household settings and single-occupancy rooms isolated residents with COVID-19 in their own rooms.

Residents' movements were restricted in large, multi-story buildings, especially in common areas where residents were not able to maintain social distancing. Restrictions were designed to facilitate social distancing, avoid cross-contamination between different households, and limit access to dining spaces. Providers in the countries and regions that did not have high infection rates were less inclined to restrict residents' access within a building. Likewise, organizations with small, household-style settings were less likely to restrict movement within the small units. Most providers reported that they would not want to restrict residents' movements in the future.

Several features of the physical environment were helpful in preventing infection. These characteristics included:

- A safe outdoor space.
- A household model that included private rooms.
- Corridors wide enough to allow for social distancing.
- Enhanced ventilation.

Multi-story buildings with elevators and long corridors were problematic. In particular, providers from low- and middle-income countries stressed the importance of controlling infection by keeping the environment clean.

THEME 3: POLICIES AND GUIDELINES

A gap often existed between policies and guidelines required by governments and the practical approaches that providers felt they needed or found useful. Guidelines and policy suggestions prepared by governments and/or associations were helpful, providing basic advice that providers could adapt to their care settings as needed. However, these policies and guidelines sometimes lacked practical utility. In addition, sets of guidelines could be confusing or even contradictory, especially if they were developed without consultation with providers or provider associations.

Providers received frequent policy-related communications from multiple sources, especially at the beginning of the pandemic. Many providers said this information was updated frequently and provided by multiple sources, which made it difficult for them to keep up. The timing of the information distribution was also problematic. Policy updates were normally issued on Friday evenings, making it challenging for providers to comply in a timely manner, and adding to the stress that already-overtaxed teams were experiencing. Providers reported that coordination has improved over time.

Several providers offered advice on how to improve policies and guidelines for future pandemics and other emergency planning. Many providers suggested that policy makers consult them when developing guidelines in order to ensure that those guidelines are relevant to elder care settings and will help frontline workers respond effectively to health emergencies. Other suggestions included:

1. Provide consistent and standardized guidelines.
2. Create flexible guidelines and policy recommendations that providers can customize to their care settings.
3. Offer guidelines that are easy to implement.

Regarding the contents of guidelines, providers suggested:

- Adding information about financial relief (Mexico).
- Facilitating peer-to-peer knowledge exchange partnerships (Japan).
- Integrating more support for emotional health, given the pandemic's impact on the mental health of both staff members and residents.

In Their Own Words:
Policies and Guidelines

> Group of academics and doctors stepped up and developed a guideline to help elder care providers, since the government did not issue a guideline for the COVID-19-related responses.
>
> — *Doctor in Brazil*

Key Lessons

The vulnerability of elder care settings during COVID-19 has highlighted systemic challenges that this sector faces.

Learning from past crises and developing a deep and multicultural understanding of the ongoing crisis may help elder care providers better prepare for future pandemics. These key lessons emerged from interviews with providers and other stakeholders around the world:

Fostering Equity

- Eliminate the global inequities experienced by elder care providers that were highlighted by COVID-19, including unequal access to tests, PPE, and technology. For example, provide up-to-date online information that providers in resource-poor countries can access when developing education and training materials.
- Develop a global network that encourages providers to share their procedures and educational materials.
- Make it easier and less expensive for staff and residents to access broadband internet connections.
- Prepare an international standard for PPE quality control and develop equitable distribution strategies and networks. Make sure this standard requires that PPE and other resources be distributed equitably to elder care settings and acute care settings.

Learning from Experience

- Study past experience in order to learn what knowledge can applied to future emergencies. COVID-19 lessons cannot be applied unilaterally to future pandemics, just as experience and knowledge from the SARS outbreak cannot be applied unilaterally to COVID-19. At the same time, however, learning from the SARS virus did help providers prepare for infection control during COVID-19, and learning from COVID-19 can help us prepare for the next pandemic.
- Share globally the lessons frontline care providers learned during the coronavirus pandemic. Such sharing can advance care quality and aid in preparation for future virus outbreaks. Public policies and treatments developed in acute care settings were shared between nations, but there was limited global learning exchanges among elder care providers.

Protecting Human Rights

- Create a balance in future pandemics between the dual needs for social interaction and infection control by developing a creative system that can keep residents safe while allowing them to receive visitors.

- Develop effective strategies that would enable residents to leave their rooms during future pandemics, rather than requiring residents to remain isolated for a long period of time.
- Explore other issues involving human rights restrictions during a health emergency, including how to support decision-making and choice among residents with dementia.

Supporting the Workforce

- Integrate mental health support for both residents and staff members into emergency preparedness plans. In-service trainings are currently focused mainly on infection control and usage of PPE.
- Develop training and education through e-learning and social network platforms such as Facebook or WhatsApp.
- Develop systems for awarding formal recognition, including hazard pay and bonuses, to staff members who take extra steps to protect residents during public health crises. Many staff members worked overtime or even stayed overnight at their care settings during the COVID-19 lockdown, often putting themselves and their families at risk. Yet, their contributions were not widely recognized and appreciated, especially in comparison to the recognition acute care workers received.

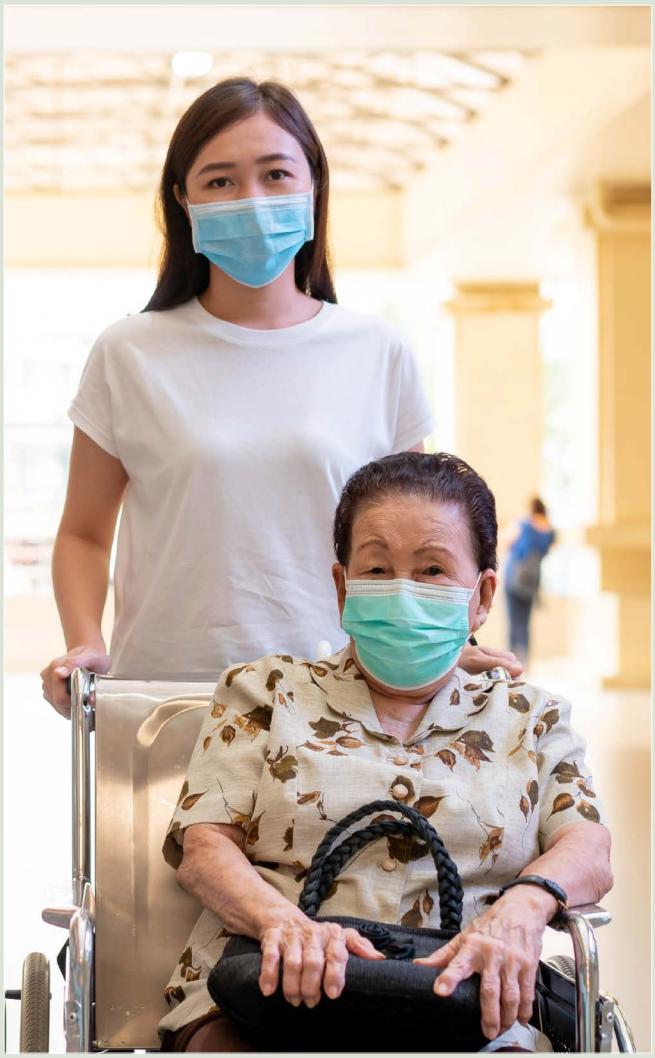
In Their Own Words:
Lessons Learned

I think the best COVID prevention is to take care of each other. I think that's worldwide: help each other, take care of each other, be careful, keep your distance.

— Provider in the Netherlands

Adapting the Physical Environment

- Design buildings for infection control, including features such as small-scale household units, private ensuite rooms, safe outdoor spaces, wide corridors for social distancing, and enhanced ventilation, including windows that open. Whenever possible, avoid or phase out multi-story building with elevators, long double-loaded corridors, and shared rooms.
- Minimize cross-contamination within buildings by assigning the same group of staff members to care for the same group of residents. Cross-contamination can also be avoided by creating small household environments that are staffed by a consistent team.



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Developing Effective Policies and Guidelines

- Ensure that policies are relevant to elder care settings by including elder care providers in the development of those policies.
- Streamline communication channels for policy and information updates, and manage the frequency of those updates.
- Require individual providers to develop strong infection control procedures of their own, rather than relying too much on national guidelines. For instance, many elder care providers took it upon themselves—before governments issued directives—to protect residents from COVID-19 by restricting visits to their care settings.
- Encourage local experts to develop guidelines to help local elder care settings respond to health emergencies. This approach proved very helpful in Mexico and Brazil, where the national governments did not acknowledge COVID-19 as a pandemic.

Advocating for Elders and Caregivers

- Develop local support networks of elder care providers who can share resources and advocate for the needs of elders and their caregivers.

Next Steps

This study examined the experiences of elder care providers during the first 9 months of the global COVID-19 outbreak. Further study is needed to update the status of providers' responses, including their vaccination strategies.

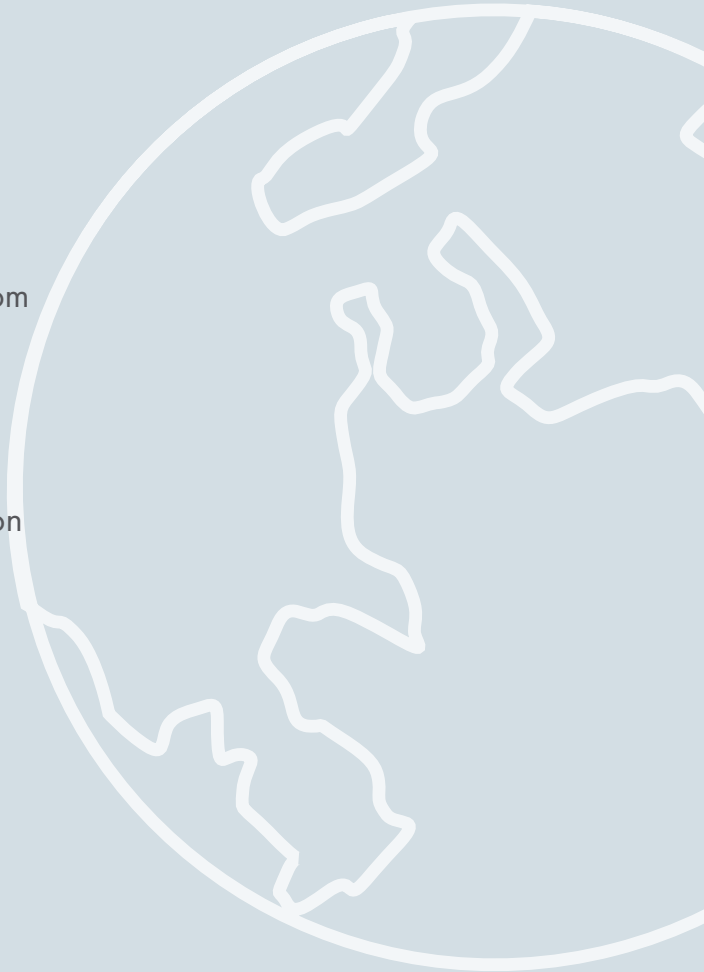
Providers from 11 countries participated in this study. While the gathered data was useful, the sample should be expanded and diversified in order to:

- Understand more fully the global challenges associated with the pandemic and lessons learned.
- Collect more information from low- and middle-income countries to better understand equity-related issues.
- Investigate the financial impacts of COVID-19 on elder care providers.

Concluding Thought

More than a year after the world began living with COVID-19, we are still learning how to protect elders from the virus's devastating effects. It is important to capture and share the experiences and knowledge gained by providers on the front lines of long-term care, the sector hit hardest by the pandemic.

Traditionally, there has been too little global collaboration and information exchange in the long-term care sector, but this pandemic provides us with an opportunity to improve on that record. The Global Ageing Network hopes this report will stimulate discussions among elder care providers worldwide, and facilitate the creation of resilient networks that can help us survive global pandemics and other emergencies in the future.



APPENDIX A: Interview Guide for Providers

Preparedness

1. Did you have emergency preparation plan/procedure/organizational approach?
2. Did you have infection control plan?
3. Were your plans effective to prepare for the COVID-19?
4. Have you received any prior information specific to preventing transmission of COVID-19?

Immediate response

Workforce

1. Have you provided any in-service training or education to the staff due to COVID-19? What was included in those?
2. Have you provided any support to the staff due to COVID-19? What was included in those? (e.g. child support, housing allowance, transportation allowance, mental health services)
3. Have you change staffing capacity and patterns?
4. Have you lost staff? Which levels and job categories? How did you recruit new staff?

Immediate response

Visitors

1. What is your current policy for visitors? Any exception?
2. What has your care setting done to communicate with family?
3. Is the care setting offering alternative means of communication instead of visits? What are those?

Immediate response

Testing and screening

1. Are you screening residents? How are you screening them/what questions are you asking them? How often? What is included?
2. What is happening with resident movement in the care setting? Are residents advised to stay in their rooms? What is the protocol?
3. Are you testing your staff members and residents? How often? Who pay?

Immediate response

PPE

1. What is your care setting doing to try and conserve PPE? Are you aware of the recommendations to conserve PPE? Do you have a backup plan if you don't have enough?
2. What PPE is being used by direct care workers who are caring for anyone with suspected or confirmed COVID-19?

Immediate response

Communication

1. Have you communicated with health department in regards to COVID-19 infection situation in your community?
2. Where and who do you seek for advice for COVID-19 related infection control issues?
3. What were the barriers that prevented you from addressing the COVID-19 outbreak effectively?
4. Have you partnered with any organizations to help each other? How?
5. What partnerships in preparing, addressing COVID, and reopening? Have type and nature of partnerships changed as a result of COVID? Lessons learned?

Immediate response

Built environment

1. What have you changed to improve to prevent infection?
2. Have you created COVID-19 units?
3. Have you limited residents' usage of shared spaces? Where and why?
4. What is your perceptions of impact of physical environment on spread of the COVID-19 virus?

Policies and guidelines

1. Were policies and guidelines developed for COVID-19 helpful?
2. Was support from policy makers well-coordinated?
3. How could the policies and guidelines be more helpful for providers to prepare infection control?

Moving forward: Lessons Learned

1. What is unique to COVID-19? What can be learned and applied to better practice more generally?

APPENDIX B: Analytical Matrix Chart

Data from this study were analyzed using the grounded theory approach to find emerging themes and key learnings. Contents from interview transcripts and researcher's notes were used to learn about provider experiences involving infection control preparedness, immediate responses to the pandemic, and policy perspectives. The researcher created this analytical matrix chart to compare similarities and differences among the 11 countries.

PREPAREDNESS			
Emergency preparedness and infection control			
Country	**Emergency preparedness plan**	**Infection control plan**	**Were your plans effective in helping you prepare for the COVID-19 pandemic?**
Argentina	Yes	Yes	Yes. There was an emergency procedure before the COVID-19 pandemic, and specific plans were developed in March when the pandemic reached our country. We stayed free of COVID until July 2020.
Australia	Yes	Yes	Yes, in a limited scope. It was also inadequate because of the unknown and changing knowledge about the COVID-19.
Canada	Yes	Yes	No. We were used to influenza, but weren't prepared for the traumatic nature of COVID-19. We did not anticipate PPE being an issue.
Japan	Yes	Yes	Yes. Basic knowledge and techniques for the infection control and pandemic planning helped to prevent virus in the organization. It helped us to keep COVID-19 free up to now.
Mexico	Yes	Yes	No
The Netherlands	Yes	Yes	Yes
Nigeria	Yes	Yes	
Singapore	Yes	Yes	Yes. Communication was streamlined from 2 ministries to 1. Infection control plan was effective, but COVID-19 was challenging due to the high level of infectiousness. Asymptomatic condition added more complexity to infection control.
South Africa	Yes	Yes	No. Infection control plans did not prepare us for what we had to deal with in the time of COVID-19.
Spain	No	Yes	No. It was difficult to handle the magnitude of the infections and number of elders.
The United Kingdom	Yes	Yes	Yes. Infection control procedures were in place and staff were confident with managing flu outbreaks procedures. However, we were not prepared for the speed and effect of the COVID-19 virus. Changing government guidance regarding the use of PPE and lack of testing was a challenge. The British Geriatrics Society raised awareness of soft symptoms, enabling us to isolate quickly.

IMMEDIATE RESPONSE		
Workforce		
Country	**In-service education and training for COVID-19**	**Support for staff members during COVID-19**
Argentina	Yes. An infection disease specialist prepared protocols and everyone has access to these protocols to review whatever they need.	Personal protective equipment for staff to use outside the organization, mental health support.
Austrailia	Yes. Education/trainings focused on infection control, including proper usage of PPE and government updates. Online training modules were also available.	The government gave support: childcare support, paid sick leave, Hotel for Heroes. Organizations self-funded emergency funds for staff and family. Employee Assistance Program in place. Additional counselling and supports offered to staff.
Canada	Virtual trainings that covered all those mandatory requirements, such as properly donning and doffing PPE, and how to go into and out of an isolated or quarantined rooms. We were able to track whether staff completed online education.	Financial recognition: success award and success points, paid leave. Emotional support through learning circles focusing on how people are feeling and how we can support each other.
Japan	Training and educations were suggested and organized by the national government. Most of the trainings taught basic skills for infection control. Some cities took leadership in developing a support network to discuss how to deliver education on COVID-19.	No support from the organization, but government distributed bonus (1,000/person for non-infected organizations, and 3,000/person for infected organizations) to help staff members.
Mexico	Online course to learn about the symptoms and consequences of COVID-19. Education was offered for staff members to learn how to change daily life inside the residence, how to clean the house, how to separate people who did not have COVID from people who did have COVID. Training was developed by geriatricians for staff and family members.	Made sure to secure job and income for caregivers. Provided paid leave for staff members who need to be quarantined.
The Netherlands	We provided e-learning for care staff and people who used to work in the offices; we trained them to care for residents.	Emotional support, mental health support from organization, and paid leave from the government.
Nigeria	Yes. All staff were given health talks about COVID-19, its mode of transmission, features, and steps to be taken when COVID-19 infection was suspected.	The care setting supplemented, in a little way, the feeding of the caregivers.
Singapore	Both electronic and in-person trainings were provided to guide to all staff members. Town hall meetings were held to get input from staff members.	Emotional support from psychologists and pastoral care. Everyday life support such as cloth masks, supermarket vouchers, and meals and snacks from organization. Paid leave and COVID-bonus for staff were provided by government.
South Africa	Yes. We focused on COVID-19 and infection control.	Recognitions and messages. Financial support that allows staff to stay in the building, including meals beds, blankets, and mattresses. We converted our communal spaces into living areas for our staff.
Spain	COVID-19 specialists in each building have met every week with all the managers.	Emotional support to staff members and coaching for managers
The United Kingdom	Locality-based practice development facilitator (trainer) on site in each village enabled us to continue with a mixture of safe face-to-face training and eLearning. Good support and resources available to assist with COVID awareness. We developed our own COVID procedures and guidance based on best practice.	We offered psychological support, paid leave, furlough, gratitude gifts and vouchers. Telephone advice service was offered to Assured' program. We also hosted regular Zoom support meetings for managers and "We Belong" forums through the support group.

IMMEDIATE RESPONSE		
Workforce		
Country	**Staffing capacity and patterns**	**Have you lost staff? How did you recruit new staff?**
Argentina	Yes. Increased basic staff to cover possible sick leaves.	Yes. We had many people who got infected by COVID-19 from July up to this date. We lost 12 frontline caregivers. We recruited only nurses and geriatric assistants.
Austrailia	No. No change of staffing patterns in the non-COVID sites, a few extra people came in to help monitor the screening of staff, residents, and visitors. Added clinical experts centrally and at the sites where COVID was present.	Yes. 75 staff were furloughed or at home on leave (out of 140 staff). State helped bring surge workforce as required and when available. Also moved staff between sites, especially when more expert clinical support was required. Lots of absences. Some staff resigned because they felt they were in a high-risk category, and they didn't want to stay in an environment like aged care. Others who just didn't like the additional burdens stated, "It's just too hard."
Canada	Yes. We used cohorting not only for residents, but also for staff. In some cases, we had to go to 12-hour shifts, or we had to add extra shifts throughout the day so that team members didn't lose any time, but were only working in a certain neighborhood. Staffing change through internal movement in the decentralized neighborhoods.	Yes. About a third of our workforce was not able to work, and the major reason for that was a single-site directive issued by government. Also, there were a number of team members who were scared and didn't want to work. From recruitment standpoint, we had a number of colleges that were able to help out, and were able to get a lot of students hired. Our best recruitment is word of mouth through our staff, through Facebook and our website.
Japan	We added the capacity in long-term care by utilizing internal staff members from day services and other elder care services within the organization that were closed during the shelter-in-place period. Overall capacity has not been affected.	Not so far. Some staff members were nervous, but no one left their job.
Mexico	Capacity of staffing couldn't be changed due to the need to provide demanding care for people with dementia. Divided staff into 3 different shifts and each group stayed on site for 15 straight days and 30 days off. We aimed for staff lived in the home or in their residence. But many of the staff have little children and are single mothers.	Regardless of COVID-19, we hired new people from other senior residences that had more staff than they should, or residences that closed their business because of financial problems. Everybody stayed in their jobs.
The Netherlands	Yes. Staff arranged their own work schedules and worked a lot more shifts than they used to work. No volunteers were able to enter the care setting at the beginning of pandemic. We added doctors to our staff.	No. Providers did not see much turnover. They think that caregivers were proud of their job, felt needed, and wanted to take care of residents. However, care settings also had some illnesses among the staff due to COVID-19. They worked with employment agencies to recruit new nurses.
Nigeria	With the reduction of reported cases in Benin City, caregivers were allowed to go away for their off days. On return to care setting, they had to wash and change their clothes before coming in contact with other caregivers and residents.	A middle-aged caregiver left the care setting. New staff were recruited through friends of the care setting.
Singapore	No new staff members were added, but more staff members will be needed over time to cover fpr staff members on sick leave.	Yes. Small numbers of nurses (from overseas) were so concerned for their families that they decided to resign and go back to their homelands. Another provider did not lose any staff members.
South Africa	We provided 24-hour care. We had to adjust the shift work to day-off and day-on, and 12-hour shifts. We adjusted the staff who were deemed essential. Everything was cut down to what was absolutely necessary for survival as opposed to a nice environment to live in.	Yes. One or 2 of our staff members were concerned about infection and we had to work through what the concerns were.
Spain	Yes, but we relaxed it a little bit in July when the state of alarm was finished.	Yes. We had to create a team to find people to replace all the people who were going home.
The United Kingdom	No problems. Initially it was about making sure the households kept the same teams in place. We started a central workforce recruitment effort, so vacancies anywhere in the organization could be filled. Having extra ancillary staff (e.g., bistro, hairdressing, gym, and activities) helped us to cover.	Yes. We have lost some new starters due to the pandemic. It has been difficult to settle new colleagues with PPE and different ways of working.

IMMEDIATE RESPONSE			
Visitation			
Country	**Current visitation policy**	**What has your care setting done to communicate with family?**	**Alternative means of communication instead of visits**
Argentina	No visitors, except external doctors in urgent cases, essential maintenance	Telephone calls, e-mail, video calls	Phone calls, video calls, emails with photographs of residents.
Austrailia	Our organization allowed visitors until state directive (or limited visiting in area with high COVID19 cases), while some services in the country ceased allowing visitors prior to the pandemic taking hold in their region. Currently, restricted visitation hours are available, no mask required in non "hot spot" areas. Visitors can now meet communally, get a coffee, walk residents outside. Full screening of all visitors in place. No appointment required to visit on weekdays, appointment only on weekends.	Letters and emails to family members every day in outbreak hotspots (weekly update now). Facebook website, phone, and in person. Also, preemptive letters to all residents describing "what to expect" if site is exposed to COVID19.	iPads made available to all services so residents could access Skype, Facetime, and Zoom. Phone and letters also used. Volunteer group from the St. Johns Ambulance Victoria, trained in first aid and first responder protocols for event management, provided additional staffing support in sites with COVID19.
Canada	In March, we started out with no visitors. And then we got some protocols that we could have visitors for compassionate care. Visitors register in advance for restricted visiting hour in a certain, very sterile location. Visitors are supervised, not allowed to touch, must wear PPE, and can't eat together.	Letters, e-mail, website, and social networking services.	Virtual visits: adding more iPads, telephones, computers with Skype, Zoom, FaceTime, and so on.
Japan	Visitors are allowed with appointment and are limited to visiting their loved ones in their room. All the visitors are screened and sanitize their hands at the entrance. Visitors should wear masks.	Letters, e-mail, website, and social networking services.	Staff members help residents connect via technologies, phones, tablets, and smart phones.
Mexico	No visitors indoors. Visitors can visit the residents from the garage. Outdoor visits with masks/shielding and sanitizer within a limited time	Phone calls, videocalls, WhatsApp chat group for residents with their family. We send daily pictures.	Phone calls, videocalls, send photos, videos. Families can contact administration to set up ZOOM conference calls.
The Netherlands	We followed the national program, which requires advance registration with name, telephone number, and health condition. Providers allow a maximum of 2 persons for a resident per visit. Visitors must wear a mask, wash hands, go straight to their family member's room, and stay in the room with the resident.	Phone and emails, letters	Live-in college students set up tablets for communication through Skype or video telephoning.
Nigeria	Visitors must wearing masks, wash hands on arrival. There is no touching, shaking hands, or hugging. Visitors maintain social distance in the building.	Phone, video, and text messaging through WhatsApp	Phone calls (including video telephone calls) and text messaging through WhatsApp
Singapore	Restricted visiting hours with advance registration, 2 visitors at a time. Exception at the time of lockdown for residents receiving palliative and end-of-life care.	Phone and emails	Mobile phone calls to family members on a daily basis. Tablets with SIM technology; staff members used their own phone to help residents contact their families.
South Africa	Scheduled visits, in a communal space, and strict screening	We provided regular updates on social media, set up family WhatsApp groups, send SMS messages, and set up communication champions in the buildings.	Yes, but it was quite limited due to the cost. Also, our elders didn't always have the technology.
Spain	Visitors could only visit 1 person once a week for 1 hour with advanced appointment.	Phone and apps, and phonic calls	Yes
The United Kingdom	Restricted visits were allowed and supported by the relatives groups and John's Campaign, which represents the rights of families and relatives. We used the essential visitor approach allowed for end-of-life care, people who were distressed, or living with dementia. Visits was allowed at outdoor and restricted spaces like the bistro. We have person-centered visiting plans.	Phone calls, emails, WhatsApp, Facetime	We utilized relatives gateway with person-centered software; and care planning using phones, tablets, and laptops. We added tablets to facilitate FaceTime conversations with families.

IMMEDIATE RESPONSE		
Testing		
Country	**Screening and testing policies for residents and staff**	**Restriction of residents' movement**
Argentina	PCR test every 10 days to all the staff who were in close contact with residents (nurses and geriatric assistants)	Strict isolation in resident rooms during the outbreak. Otherwise, residents are isolated by cohorts on their floors and we control that no more than 4 residents are in common spaces at a time. Residents are separated and in ventilated areas.
Austrailia	The commonwealth government is now doing some local PCR tests. Screening is available for residents. How often this is undertaken Depends on local risk and "hotspots." In sites where COVID19 is present, screening for staff and residents was completed every 2 days.	When there was a infection in the building, residents are restricted to room only. In the building without infection, only unwell residents are isolated, but residents' activities continued with cohorting and social distancing.
Canada	Active screening with a comprehensive check-up for residents, twice a day. Test only when residents display symptoms. Staff is tested twice a month. Staff are screened in the morning when they come in, and when they're leaving. We conduct contact tracing for staff who test positive.	There were points in time when the buildings were completely shut down, internally, and residents were quarantined in their rooms. Residents are not mixing from one neighborhood to the other. There is no access to dining rooms. Residents could go to their outdoor area using designated elevator.
Japan	Standard screening with temperature and checklist, but we only test when residents and staff shows any symptoms. Government pays for tests for residents who display symptoms.	No restriction for residents' movement within the care setting. Residents are not advised to stay in their rooms. Residents are restricted from leaving the campus, but can go out with permission.
Mexico	Some care settings screen residents 3 times a day and others screen 4 times a week. Test new residents or ones with symptoms and new resident coming into the house.	No restrictions.
The Netherlands	We actively screen on signs and symptoms of COVID-19. We immediately isolate and test residents displaying symptoms.	
Nigeria	Residents are screened. Residents are asked questions designed to pick up symptoms of COVID-19. Testing is not being done for both residents and staff due to the short supply of testing kits in Benin City.	Residents allowed to leave for care setting for medical visit only. Residents are allowed out of their rooms to watch television, eat their meals, sit out in the living room, and walk around the care setting.
Singapore	All residents in nursing homes in Singapore were tested in May, 2020. We test residents only at the admission, and when they have acute respiratory symptoms. We test new staff or staff with acute respiratory symptoms. Testing is funded by the government.	Residents are not allowed to leave their wards. Residents are mainly housed in cubicles with several residents within a cubicle. Movement is restricted within the household
South Africa	Anyone coming into the building would have to be screened with a standard questionnaire. We test residents when they display symptoms.	No restriction within the property unless there was an outbreak of infection.
Spain	The tests are made always by the government. And we have no tests.	
The United Kingdom	Screening questions, PCR testing every 28 days for residents, 7 days for staff. Now increased to weekly PCR and twice weekly for staff, plus the LFD for all visitors, and interim tests for staff.	Bedroom isolation in the households if there is an outbreak in the household. Isolation in rooms for 14 days for all admissions. If no outbreak, no restriction in the cohorted households. Apartments can form support bubbles according to restrictions. There was some use of venue, gym, and salon according to local tier restrictions.

IMMEDIATE RESPONSE		
PPE		
Country	**Acquiring PPE**	**PPE gear for positive COVID-19 cases**
Argentina	The N95 masks are conserved in paper bags between uses. We have access to materials without problems, but we buy for 2 months at a time to avoid running out of materials.	Since our outbreak in July, we permanently use N95 masks, surgical masks, plastic face protection masks, disposable gloves, and waterproof camisoles.
Austrailia	Clear on giving instructions about PPE and appropriate PPE use. Emergency supply of PPE in every single site and it is under lock and key so that supply is ready and available for immediate deployment on presentation of active case. Careful monitoring for PPE usage.	Eye-shields, masks, gowns, gloves, and hand sanitizer.
Canada	We did not have all of our staff fit-tested for N95 masks. We worked with SGP, a subsidiary of a large long-term care provider across Canada, to acquire PPE. Currently, we are stocking enough PPE for a month. The government has subsidized the price gap for that cost.	Standard surgical mask, goggles or face-shields, and gloves.
Japan	PPE was available but it became 3-4 times more expensive. The price gaps were covered by the national government. City has coordinated and distributed enough PPE.	Masks and gloves for non-positive individuals; mask, face shield, gown, and gloves for positive individuals.
Mexico	Due to the shortage of PPE, providers need to buy the masks through websites like Amazon, which were too expensive. We use surgical clothes, but they are not disposable.	Staff wear 1 mask for 5 shifts, and use another mask for 5 days. If we have a COVID-positive person, they need to use robe, the surgical clothes, and the disposable clothes.
The Netherlands	We experienced a shortage of masks and gowns. Our protocols called for reusing masks rather than wearing them once and throwing them away. We tried to be creative in dealing with shortages.	N95 mask, full gown, gloves, and visor/face guard
Nigeria	There are no PPE in the care center, so we cannot begin to talk about conserving PPE.	No protocol
Singapore	At the start of the pandemic, PPE was in short supply and reserved for the clinical staff. N95 and surgical masks had to be reused. But subsequently, the government has been providing PPE and there are more than sufficient stocks.	N95 mask, full gown, gloves, and visor/face guard
South Africa	Access to PPE was difficult, and the cost of PPE was so high without government's subsidy.	N95 mask, full gown, gloves, and visor/face guard
Spain		N95 mask, full gown, gloves, and visor/face guard
The United Kingdom	PPE was a concern initially back in March. We secured large amounts of PPE for all villages through various suppliers to ensure safe sessional use of masks, etc. Local authorities set up local resilience framework. A PPE portal was set up for weekly orders at no charge. We had varying experiences with this system.	Fluid-repellent (Type IIR) surgical mask, aprons, gloves, and visor/face guard

IMMEDIATE RESPONSE			
Communication			
Country	**Communication with health authority**	**Reliable COVID19 resources**	**Were partnerships established?**
Argentina	Health Ministry of Buenos Aires City Government.	Health Ministry of Buenos Aires City Government	Yes. Other long-term care settings, Argentine Infectologists Society, Health Ministry, Argentine Gerontology, and Geriatric Society. We make consults and suggestions, exchange experiences, and elaborate on common protocols.
Austrailia	Health department, State, and Commonwealth	Commonwealth, Health Department, and public health unit (HNEH).	No. There were already partnership established before the COVID-19. State and Commonwealth developed a dedicated response unit for COVID19 in State of Victoria. Took a while to have impact, but is a positive step forward.
Canada	Local public health and Healthy Authority in the region	Well-coordinated approach right across Canada, although each province has autonomy in terms of how it handles things. Local public health authority works very closely with nursing homes. Chief medical health officers in the provinces have a regular get-together where they share what they're doing.	Yes. Informal structures were put in place, resulting in closer tie with public health and hospitals. All care home administrators have always met monthly.
Japan	Report to city and prefecture	Health department in local prefecture and public health division in cities where there is 24-hour hotline for phone advice.	Yes. City takes leadership to develop peer support network to discuss solutions.
Mexico	No need to report to any authority	Our main doctor (geriatric specialist), who works directly with the National Institute of Geriatrics. We don't have policies for elder care. We developed the guideline with the Geriatric Institute. Sources included the Centers for Disease Control and Prevention in the U.S. and the National Institute of Health and Care Excellence in London.	Yes. We have been contacting other senior residences to see how they are doing.
The Netherlands	Registration with authorities. The doctor who is on the crisis team communicates with the local health services.	National infection board, our crisis team, and our internal COVID information line.	Public Health Association and the hospitals with COVID units
Nigeria	Personal connections with medical colleagues who are involved in the management of COVID-19 cases		Yes. Coalition of Societies for the Rights of Older Persons in Nigeria (COSROPIN)
Singapore	Ministry of Health	Relevant departments (Agency for Integrated Care) within the Ministry of Health.	Yes. We have a partnership with neighboring acute care hospitals, which deployed some of their doctors. Government facilitated WhatsApp group among nursing home CEO's nationwide.
South Africa	The Department of Health	National government set up a WhatsApp information line for COVID-19. Information from websites, such as National Institute for Communicable Diseases (NICD)	Informal partnerships with other service organizations to share information and support as we needed it, because as a larger organization, we were able to share our IP with everyone.
Spain	Social department and local health department	Regional public health system had a web service collecting all the information related to COVID-19.	We are in an organization that is called ACRA.
The United Kingdom	Public Health England, local health protection teams	Public Health England, local Health Protection Team, and the Infection Control Nurses.	Yes. We keep connecting to government through the National Care Forum (weekly meetings), the Care Provider Alliance, Greater Manchester Partnership, and local Health Protection Team.

IMMEDIATE RESPONSE		
Built Environment		
Country	**Any change to or improvement of environment?**	**COVID-19 units**
Argentina	No change	No COVID-19 units.
Austrailia	No structured change. Handwashing facilities. Set up cohorting staff areas to enhance social distancing. Setting up handwashing and screening stations (including some outdoors prior to entry).	Yes. Cohorting and segregation of "green, orange, and red zones." Put up plastic drop sheets to divide the space and manage air flow and foot traffic.
Canada	No structured change. Removed furniture. Changed the dining room setting. Changed semi-private rooms into private room.	Cohorted residents. (They just stayed in the same neighborhood.) Residents who tested positive were isolated in their room.
Japan	No physical changes since there are no positive cases in the community. Operations paid more attention to ventilation in the building.	One COVID-19 room per building has a negative pressure room. Construction cost is subsidized by national government.
Mexico	No.	We didn't need to because we have a 12-bed dementia unit that has single rooms. One room is designated as an isolation room for COVID.
The Netherlands	No structural changes. We placed stripes and arrows everywhere to guide people on how to go to places with careful consideration of infection control. We used stickers to mark off 1.5 meters to ensure proper social distancing.	No. Everyone stayed in their own room. During the first wave, we already had COVID-19 units for the region but not for people with dementia.
Nigeria	No physical change: More attention is being paid to general cleanliness in the care setting and its environment. Special attention is being paid to the personal hygiene of residents and caregivers.	No.
Singapore	Converted meeting rooms into staff rooms. The lifts are now locked to specific floors. Safe distancing markings on the floor.	Only when we were operating 2 COVID wards did we have COVID units. No COVID unit in the nursing home with the small household environment.
South Africa	No structure changes. Rearranged seating in dining room	No.
Spain	No structure change. Very strict segmentation of the residence. Smaller units, , because at home you prefer to be in a little group of people, not with more people.	Yes. By protocol, we have to create different COVID-19 units in every care setting.
The United Kingdom	No. We didn't have to but we have reviewed the design brief and sought feedback. The household model has been effective. The space in the core of the village has been useful for safe visiting. Apartment corridors have created isolation for tenants	No. If we had a positive case or 2, then that household would be isolated and be recognized as an outbreak in that household.

IMMEDIATE RESPONSE		
Built Environment		
Country	**Limiting residents' use of shared spaces**	**What impact did the physical environment have on spread of COVID-19?**
Argentina	Yes. We did it when we had the outbreak.	Well ventilated areas, with adequate social distance and strict control of workers who circulate out of the institution. Using the complete PPE permanently has been effective to prevent new outbreaks.
Austrailia	Yes. Set maximum numbers and cohorted residents to reduce cross-infection across care units. Dining rearranged.	Multi-story care settings without good ventilation were an issue.
Canada	Yes, but, not in their neighborhood, so long as there were no positive cases of COVID-19.	Wide corridors allowed for people to pass by in the hallway safely. Neighborhoods with private rooms worked better because the suites and hallways are a bit bigger in size. Private room with bathroom is helpful for infection control.
Japan	Usage of the spaces within the households were not limited, but residents were not allowed to go to other houses. No restriction for the space where residents could go within the building.	Small household setting made it easier to manage the infection control during COVID-19 pandemic time.
Mexico	Residents can go anywhere inside the house.	
The Netherlands	Yes. Residents were only allowed to stay in their own room, and restaurant was also closed .We opened shared spaces in July after the first wave and we don't want to close them again because that's our socializing system in the house.	The corridors are very long, and it's very difficult to cohort residents and staff members. It was also challenging to close down a part of the corridor on a floor.
Nigeria	No.	An unhealthy, dirty environment will encourage spread of COVID-19 infection.
Singapore	Yes. Residents had to stay within their wards and could not go to common areas. Residents stayed within their household, and were not allowed to go to other houses.	The environment of the small household model was helpful. At large buildings, we needed to close shared spaces, including dining space, and residents were forced to stay in beds.
South Africa	For the most part people stayed in their rooms, especially for the first 21 days.	Adequate outdoor space for people who want to move around the building and the car park
Spain		
The United Kingdom	If there is a positive case or 2, then that household would be isolated and be recognized as an outbreak in that household. If 2 or more households have an outbreak then village movements would be restricted and visiting stopped.	Small household settings worked better since residents' movement was less restricted and residents/staff teams could be cohorted.

POLICIES			
Policies and guidelines			
Country	**Were the policies and guidelines developed for COVID-19 helpful?**	**Was support from policy makers well-coordinated?**	**How could the policies and guidelines be more helpful for providers preparing infection control?**
Argentina	Yes.	It was very different in different parts of the country or provinces, which was sometimes confusing.	Guidelines changed frequently because of the scarce knowledge around this new virus. We are all always learning more.
Austrailia	Yes. There were contradictions in guidelines sometimes. We developed our own protocol based on the guidelines.	Support varied at different times due to State and Federal issues, but was mainly good. Updates could have been better coordinated, they always came out late Friday afternoon after we went home. Otherwise, updates got better over time.	More consistency and standardization will be helpful. Have 1 source of truth, allow each care setting to make its own assignment. Add funding to enact all new policies and expectation
Canada	Yes, but when the decisions are made provincially, they don't understand the practical ramifications. Decisions are made with the best of intent, but I don't think they understand the local impact of what that directive means. Some regions of Canada haven't been as good or as strong.	No, every public health agency did something different, or a different variation of the standard. When we brought information back to the provincial taskforce about what was actually happening, the provincial government was confused as to why that was happening the way it was. Having one health authority was advantageous.	More ties with science and policy and guidelines. Off-the-shelf protocol: if you could just take it right off the shelf, maybe just press a button and put your logo on it, and you're done.
Japan	The guidelines published by the ministry helped us gain basic information. However, we needed to customize the guidelines for practical use. Smaller care settings may need more concrete advice than the basic guidelines that were provided.	Messaging strategies were not well coordinated and it created confusion. City has coordinated the information providers need to know.	Timing of the distribution of the guideline is critical. Coordinating/facilitating peer-to-peer partnership and support system by local government would be helpful. Streamline communication strategies to avoid confusion for providers and family members. It would have been more helpful to have front line providers give advice to policymakers.
Mexico	Guidelines were helpful to stop the virus outbreak, but not to help companies survive financially.		There should be policies to help companies financially; for example, adding information for financial relief. Create instructional video, similar to videos we created with Alzheimer's' Association.
The Netherlands	Yes. I think it's very necessary to build on knowledge and lessons learned, and to develop further. So, maybe next month, we will have new insights or new knowledge, and then we will build on that further.	Yes. Our daily briefing was very good in the period when we had really high rates of infections.	Be clear and be straight. Say "yes" and "no," and that's it. Avoid ambiguous advice.
Nigeria	Yes.	No.	There needs to be more health education for and more interaction with people at the grassroots.
Singapore	Yes, essential.	Yes, the Ministry had learned lessons from the previous SARS pandemic. At the start of the COVID situation, there was some confusion among the different sectors of government, but these soon were settled. It was a clear chain of command.	Sometimes the Ministry circulars may be too general, and need to be very specific for the target segment. More support for mental status is ideal.
South Africa	Some of it was helpful, some of it was confusing, especially when you had general provisions in terms of the state of disaster and the regulations coming out of different departments.	No. The disconnect between the different levels of government translated into a fragmented service being implemented on the ground.	If there was a space for providers to be part of the policymaking process, it would help in implementation.
Spain	Yes, but there were many confusions also.	No. We could not trust policymakers until May about anything that came in.	
The United Kingdom	Yes. But too many changes in the first few months were confusing and distressing. Changes were made without consulting with the sector, and that had an impact.	No, not initially. It took some time, but it helps to have a voice through the National Care Forum, to be able to feed that back directly, and the fact that they sit on committees.	Constantly seeking and consulting before policy is implemented, listening, pilot testing, and testing out the impact and the cost, etc.

APPENDIX C: Resources

Argentina

Protocolos de actuación para prevención y manejo de casos sospechosos de Coronavirus en residencias geriátricas. Buenos Aires, Argentina (Spanish only)
https://www.buenosaires.gob.ar/coronavirus/equipos-salud/protocolo-de-manejo-frente-casos-sospechosos-y-confirmados-de-coronavirus-covid-19-residencias-geriatricas

Japan

COVID-19 guideline for the long term care institutions for Japan (Japanese only)
https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000121431_00089.html

Mexico

Estrategias para prevenir la transmisión de COVID-19 en residencias de personas mayores(Spanish only)
http://geriatria.salud.gob.mx/descargas/covid/Guia-Prevencion-enfermedad-coronavirus-2019-09-sep-2020.pdf
http://geriatria.salud.gob.mx/descargas/covid/Estrategia-Prevencion-Control-COVID-19-23-julio-2020.pdf
https://www.gob.mx/cms/uploads/attachment/file/547811/ACTUALIZACION_PROTOCOLO_COVID-19_INAPAM_ABRIL_2020.pdf

Australia

Coronavirus (COVID-19) information and resources
https://www.agedcarequality.gov.au/covid-19-coronavirus-information

Canada

NIA myCOVIDVisitRisk *Decision Aid*
https://www.nia-ryerson.ca/covid-19-long-term-care-resources

The United Kingdom

NHS: data briefing 12 October

https://www.gov.uk/government/publications/nhs-data-briefing-12-october

LESS COVID: Learning by Experience and Supporting the Care Home Sector during the COVID-19 pandemic

https://www.nationalcareforum.org.uk/wp-content/uploads/2020/10/LESS-COVID-19-v2.pdf

The Netherlands

Corona and Nursing Homes in the Netherlands: What was the Situation in Nursing Homes?

https://www.lumc.nl/sub/9600/att/FactsheetCoronaresearchDutchnursinghomes-Minutes

https://www.lumc.nl/sub/9600/att/FactsheetCoronaresearchDutchnursinghomes-Panels

Brazil

National front to strengthen the long term care institutions for the elderly (English)

http://ilcbrazil.org/portugues/wp-content/uploads/sites/4/2020/04/Relatório-final-pt_br-en-C-1.pdf

Spain

ACRA: Associació Catalana de Recursos Assistencials

https://www.acra.cat/ca

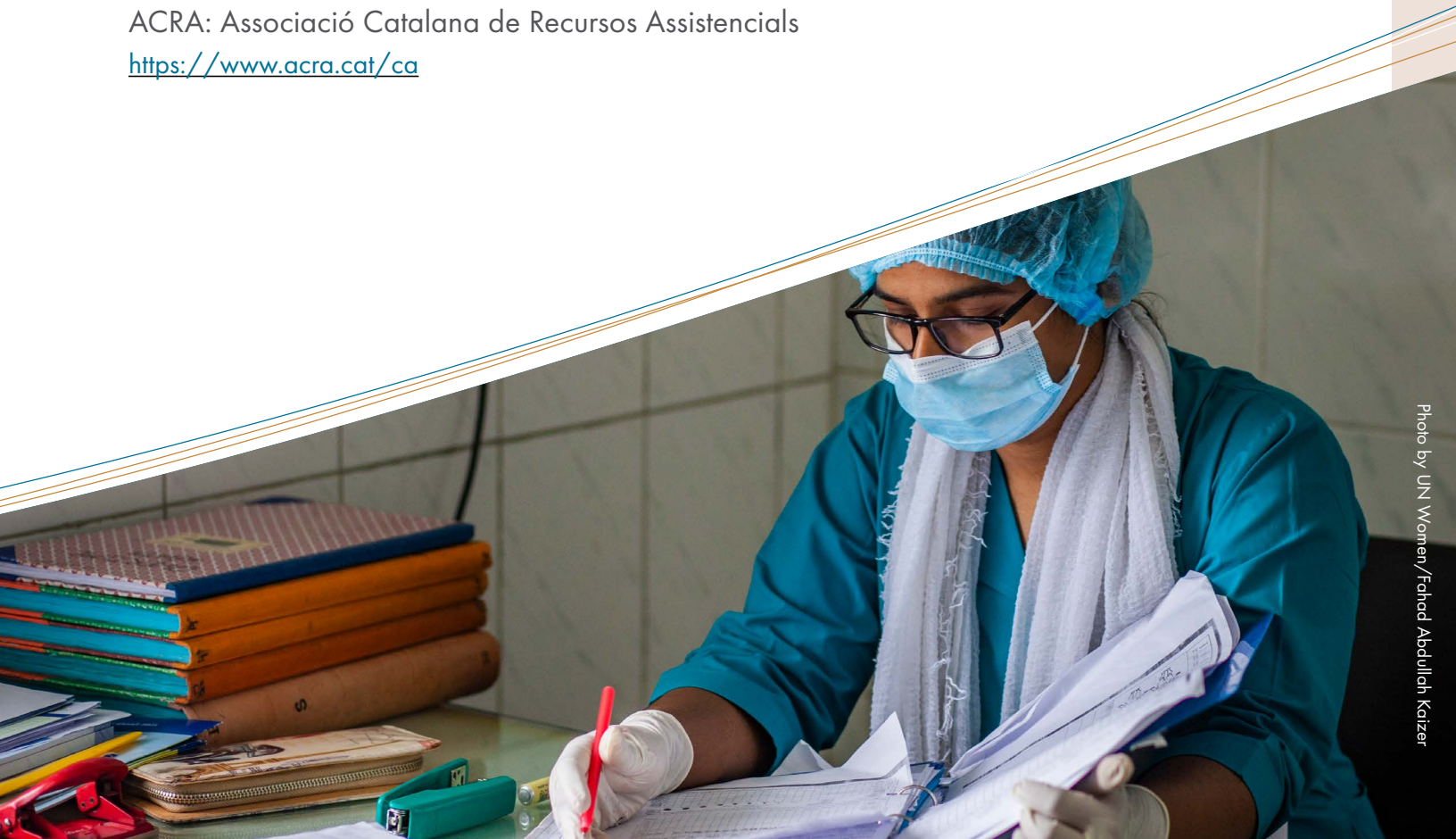


Photo by UN Women/Fahad Abdullah Kaizer

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