Table 1
Studies of Vaccine Effectiveness in LTC Users

Study (Country)	Vaccine Studied	Study Overview	VE Estimates
Britton et al[3] (United States)	BioNTech/Pfizer	Outbreak report after breakthrough infections; 2 facilities (463 residents, 81% had at least 1 dose)	VE against infection after first dose: 63% (95% CI 33-79).
Cavanaugh et al[4] (United States)	BioNTech/Pfizer	Outbreak report after breakthrough infections; 1 facility (83 residents, 90% had 2 doses)	VE among fully vaccinated residents (>14 d after second dose): against infection 66% (95% CI 41-81); against symptomatic illness 87% (95% CI 66-95); against death 94% (95% CI 45-99)
Rask-Moustsen Helms et al[1] (Denmark)	BioNTech/Pfizer	Cohort study; 39,040 residents at LTC facilities (95% vaccinated with at least 1 dose)	No protective effect against infection after first dose VE against infection after second dose: 52% (95% CI 27-69) after 0-7 d, and 64% (95% CI 14-84) beyond 7 d
Shrotri et al[2] (England)	Oxford/AstraZeneca and Pfizer/BioNTech	Cohort study; 10,412 residents at LTC facilities (88% vaccinated with at least 1 dose)	VE against infection after first dose: 56% (95% CI 19-76) at 28-34 d; 62% (95% CI 23-81) at 35-48 d

CI, confidence interval; VE, vaccine effectiveness.

summary, we are aware of quantitative and qualitative work in this area that aims to better understand willingness to be vaccinated and barriers to achieve high levels of uptake.

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Was Hospital Care Refused to Belgian Nursing Home Residents During COVID-19?

The COVID-19 pandemic exposed many imperfections in older care. Worldwide, health care workers in nursing homes

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worked hard in dire circumstances. Personal protective equipment and COVID tests often were scarce.[1] In Belgium, a particular problem arose regarding hospital admissions for nursing home residents.

During the first wave, just as any other country, Belgium was confronted with the devastating impact of COVID-19. The outbreak of the virus in Lombardy (Italy) was a wake-up call for intensivists. They warned the government of the deadly impact and virulence of COVID-19. In a reaction, the government imposed a lockdown in March 2020 to prevent a collapse of the health care system.[2]

The Belgian Society for Gerontology and Geriatrics issued directives to prevent avoidable hospital admissions and transfers from nursing homes. These directives emphasized the use of advance care planning tools to recognize older adults' personal end-of-life decisions, and urged that palliative care was more appropriate than advanced intensive care in case of a score of $\geq$8 on the Clinical Frailty Scale.[3] Thanks to the delay of nonurgent care and the creation of extra intensive care unit beds, prioritizing patients for hospital admission was never an issue in Belgium. Nonetheless, many people died, and almost half of the Belgian casualties passed away in a nursing home. Newspaper articles, including international press, presumed that these older adults were deliberately left to die.[4]

To disclose whether these presumptions were true and how these presumptions arose, a rapid qualitative appraisal was carried out. Two data sets were used: 5 reports of the COVID-19 parliamentary committee and 11 interviews with key persons in older care (n = 5) and with nursing home directors (n = 6). The parliamentary reports were verbatim reports of meetings between members of the Flemish parliament and experts and representatives from care sectors. An ad hoc committee of parliamentary members was formed to evaluate the actions taken by government during the first COVID-19 wave and to advice post-COVID policy. The committee invited experts (eg, lead geriatricians and intensivists) and representatives from, among others, umbrella organizations of nursing homes and organizations that represent older people. These experts and representatives presented their experiences, followed by an extensive Q&A with the members of parliament. For the in-depth interviews, directors of nursing homes and staff members and policy experts from the 3 leading care networks were purposefully approached and interviewed after giving consent. Open ended questions were used to encourage free narration on the topics of COVID-19 outbreaks, hospital admissions during the first wave and general policy issues. The responses were categorized around themes gleaned from the interviews.

The results from the data analysis indicate no hard evidence that hospitals refused nursing home residents.

There is, however, a strong perception that older adults were refused, and this perception originated from 5 causes according to the participants of the study.

First, there were a few cases in which nursing home residents could not get hospital care in the first chaotic week of the pandemic, while at that time the medical support in the homes was low to nonexistent. The question remains whether it was a hard refusal from the hospital or an inquiry to temporarily not refer patients because the hospital at that specific moment reached maximum capacity. Second, the transfer of a person to hospital is based on medical judgment. Medical decisions lay within the authority of each resident's general practitioner in Belgian nursing homes and cannot be made by the nursing home's coordinating physician. General practitioners stated early in the crisis that it was pointless to transfer frail residents with low survival rates, leaving residents in the often understaffed and underprotected home. Third, the directives from the Belgian Society for Gerontology and Geriatrics were misinterpreted by nursing home staff. Fourth, and in line with the former, the same directives were misinterpreted in the press. Newspaper articles stated that age, not frailty, was a factor for triage. This was the impression that was left with the general public. This interpretation also dominated discussions about transfers between nursing home staff and families of residents, who were under the impression their family member no longer was allowed in hospital. Last, there was the complexity of the crisis, numerous and often changing guidelines, and a shortage of protective personal equipment. The crisis highlighted the consequences of a long history of underfinancing and understaffing of nursing home care. This, in combination with stereotypical images of care for older people and ageism in general, nourished the perception that the nursing home sector and its residents were completely abandoned.

COVID-19 created important lessons for the future of care.[5] For Belgium in particular, an evaluation of the role and decision-making power of the nursing home's coordinating physician, increased financing and staffing, and more training in and attention for advance care planning are key. However, reflection on the role and the responsibility of the way nursing home care, older people, and the guidelines issued by geriatricians were represented in the national and international press is just as important.

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