JAMDA 23 (2022) 778–809

JAMDA

journal homepage: www.jamda.com

Review Article

Guidance to (Re)integrate Caregivers as Essential Care Partners Into the LTC Setting: A Rapid Review

Lisa M. Palubiski MD [a], Kurt L. Tulsieram MSc [b], Douglas Archibald PhD [c,d], James Conklin PhD [c,e], Jacobi Elliott PhD [f,g], Amy Hsu PhD [c,d], Paul Stolee PhD [f], Heidi Sveistrup PhD [c,d], Anita Kothari PhD [b,*]

[a] McMaster University, Hamilton, Ontario, Canada
[b] Western University, London, Ontario, Canada
[c] Bruyère Research Institute, Ottawa, Ontario, Canada
[d] University of Ottawa, Ottawa, Ontario, Canada
[e] Concordia University, Montreal, Quebec, Canada
[f] University of Waterloo, Waterloo, Ontario, Canada
[g] Lawson Health Research Institute, London, Ontario, Canada

Keywords:
Long-term care
care homes
COVID-19
essential caregiver
reintegration

A B S T R A C T

Objectives: This rapid review aimed to identify the strategies used to (re)integrate essential caregivers (ECs) into the LTC setting, particularly pertaining to principles of equity, diversity, and inclusion. In addition, this rapid review aimed to identify the strategies used during prior infectious disease threats, when similar blanket visitor restrictions were implemented in LTC homes. The review was part of a larger effort to support LTC homes in Ontario.
Design: A rapid review was conducted in accordance with principles from the Canadian National Collaborating Centre for Methods and Tools.
Setting and Participants: ECs, residents, staff, and policy decision makers in long-term care home settings.
Methods: Five electronic databases were searched for academic and gray literature using predefined search terms. Selected documents met inclusion criteria if they included policy guidance or an intervention to (re)integrate ECs into LTC homes at the local, national, and/or international level.
Results: In total, 15 documents met the inclusion and exclusion criteria. All documents retrieved focused on the context of COVID-19. Documents were either policy guidance (n = 13) or primary research studies (n = 2). Documents differed in these notable ways: Definition of EC; the degree to which an EC is recognized for her or his role in the care of the resident; the degree to which ECs are (re)integrated into the LTC setting is prioritized; response to community spread of COVID-19; visitation during an outbreak or if a resident is symptomatic; the reliance on equity, diversity, and inclusion principles; and lastly, monitoring and improving the process.
Conclusions and Implications: Using an equity, diversity, and inclusion lens, we posit promising practices for (re)integration. It is clear from the rapid review that more research is needed to understand the efficacy of policies and guidelines to (re)integrate ECs into the LTC setting. Until such evidence is available, expert opinion will drive best care practices.

The COVID-19 pandemic is a major public health threat. Arguably the hardest-hit sector has been long-term care (LTC), with a disproportionate number of COVID-related deaths.[1] Although there is not an agreed on Definition of an LTC home, Sanford and colleagues provide an international definition of a nursing home, which is a facility "that provides 24-hour functional support and care for persons who require assistance with activities of daily living (ADLs) and who often have complex health needs and increased vulnerability."[2] Sanford and colleagues[2] further add that an LTC home is a subtype of a nursing home that provides long-term care to residents rather than

This study was funded by Healthcare Excellence Canada.
The authors declare no conflicts of interest.
* Address correspondence to Anita Kothari, PhD, Faculty of Health Science, Western University, 1151 Richmond St, London, Ontario N6A 3K7, Canada.
E-mail address: akothari@uwo.ca (A. Kothari).

https://doi.org/10.1016/j.jamda.2022.01.054

short-term (rehabilitative) care. LTC residents are at high risk for morbidity and mortality related to COVID-19 for reasons that extend beyond older age, comorbidities, and other health disparities. Factors that contribute to the high-risk environment include living in an enclosed, congregate setting, difficulty maintaining distancing among mobile residents with dementia, and close physical contact with staff.[3,4] As a result of the COVID-19 pandemic, there has been a significant change in health care policies and practices, particularly in the LTC setting.

In an effort to reduce the spread of COVID-19 and preserve resources (eg, personal protective equipment), blanket visitor restrictions were implemented in the "first wave" of the pandemic where all visitors [including essential caregivers (ECs)] were restricted from entering an LTC facility.[5,6] Although there is not one agreed upon Definition, one expert group defined ECs as those who "provide physical, psychological and emotional support, as deemed by the [resident]." This can include both paid and unpaid family members, friends, and/or privately hired caregivers.

However, it soon became apparent that blanket visitor restrictions failed to distinguish a general visitor from an EC. General visitors are those who provide nonessential services or visit for social reasons. General visitors may include those who are not routinely involved in the resident's care and whose visit is social in nature. General visitors differ from essential visitors, who provide direct care that is deemed essential by the resident and/or essential caregiver. Essential visitors, in addition to direct care, provide social stimulation and meaningful connection and continuity. As a result of blanket visitor restrictions, there was a negative impact on the cognitive, mental, and physical function of residents. This included increased rates of depression, social isolation, loneliness, and behavioral disturbances.[7–9] In addition, there was unintended harm done to both ECs and care home staff, including psychological harm[7] and an increased workload on staff.[7,10]

As the pandemic progressed and the negative impact and unintended harm caused by blanket visitor restrictions were recognized, there was an increased effort to (re)integrate ECs into the LTC setting. Given the need for immediate and actionable recommendations, and in the absence of research evidence, existing policies were guided primarily by expert opinion. As a result, policies to (re)integrate ECs varied widely across homes and/or jurisdictions. As ECs (re)integrate into the LTC setting and new policies/research evidence emerge, there is a need to continually revisit existing policies, guiding principles, and research evidence to better inform policy. This will become increasingly important as we enter into new phases of the COVID-19 pandemic and lay the foundation for the next infectious disease threat.

This rapid review compared different strategies to (re)integrate ECs into the LTC setting during both the COVID-19 pandemic and prior infectious disease threats (eg, the 2003 severe acute respiratory syndrome (SARS) outbreak when similar blanket visitor restrictions were implemented). To our knowledge, this is the first systematic rapid review to look at approaches to (re)integrate ECs into the LTC setting from an equity, diversity, and inclusion lens. This review is intended to provide information to key stakeholders and policy decision makers.

Methods

Because of the urgent need for guidance to (re)integrate ECs into LTC homes, we conducted a rapid review.[11] The rapid review was guided by the methodologic framework described by the Canadian National Collaborating Centre for Methods and Tools (2017),[12] principles to improve the quality of the reporting described by Tricco et al (2015),[13] and principles to conduct a rapid review on COVID-19 by Tricco et al (2020).[14] In addition, the rapid review approach was revised on feedback from an interdisciplinary team of LTC researchers who are part of a Canadian national network aimed at improving LTC policy and practice. For a more detailed explanation of how these resources were implemented, see Supplementary Material 1.

Search Strategy

Both academic and gray literature were searched. The search strategy is further described in Supplementary Material 1. Key search terms were used for the following academic databases: PubMed, Scopus, EMBASE, CINAHL, and WHO COVID-19 repository (GOARN). A similar search strategy was used to search the gray literature. Documents from key interest groups, organizations, and institutions were identified by (1) searching the topic in Google and looking through the first 5 pages retrieved and (2) confirmed by an advanced Google search of documents using a similar search strategy as that applied to the academic literature. In addition to the above strategies, footnote chasing was used to identify any documents that were missed in the initial database search.

Inclusion and Exclusion Criteria

The title and abstract of all documents were screened by the first reviewer (K.T.) and verified by the second reviewer (L.P.) according to the following inclusion and exclusion criteria:

Inclusion criteria

Documents published in English between 2002 and 2021 were included in the review. Documents met inclusion criteria if they included policy guidance or a primary research study to (re)integrate caregivers as ECs into LTC homes.

Exclusion criteria

In addition to excluding documents that did not meet the above inclusion criteria, documents were excluded if they included a policy that had been revoked and/or replaced with a newer policy.

The study selection was done by the first reviewer (K.T.) and verified by the second reviewer (L.P.). Any discrepancy was resolved through discussion. The study selection is shown in a PRISMA flow diagram in Figure 1.

Analysis

Data were extracted into a table where the categories served as the deductive code list. The data extraction table was piloted on 3 documents and revised upon discussion from the 3 reviewers (K.T., L.P., and A.K.). The categories included aim or purpose and intended audience; Definition of an EC; study design; methodology and/or population; primary outcomes or guiding principles; policy or policy recommendations; and principles of equity, diversity, and inclusion. To analyze the data, constant comparative analysis was used with a deductive approach using our code list mentioned above and complemented by an inductive approach to identify emerging themes across the extracted documents.[15,16] The data extraction was conducted by the second reviewer (L.P.), and the extraction was verified by the first reviewer (K.T.) by comparing the extracted data with the original source to ensure accurate classification.

Results

A total of 458 documents were retrieved from the search of both academic and gray literature (see Figure 1). Of the 458 documents, 14 documents met study inclusion and exclusion criteria (5 in academic and 9 in gray literature) and were retained for analysis. Most documents were excluded because they did not include policy guidance or an intervention to (re)integrate ECs into the LTC setting. Footnote chasing added another 1 document.[17] In total, 15 documents were

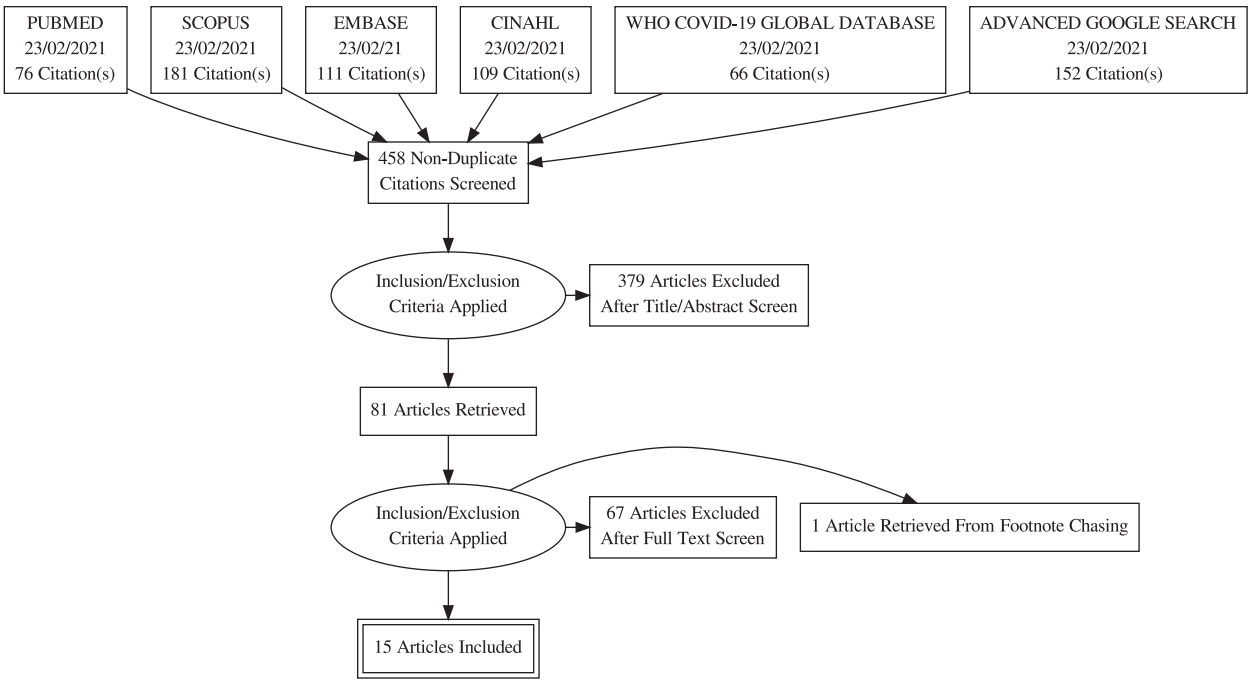

Fig. 1. PRISMA flow diagram. Five databases were searched according to the search strategy, along with an advanced google search. Articles were extracted and duplicates were removed. Remaining articles were screened according to inclusion and exclusion criteria. Fifteen articles met the criteria.

included in the analysis. Results of the data extraction are presented in Table 1. Data extraction focused on data specific to ECs and essential visits. No documents were identified from the 2003 severe acute respiratory syndrome (SARS) outbreak or other public health emergency. There was one primary research study; most documents included mainly expert opinion. Documents were published in Australia (n = 3), Canada (n = 4), the Netherlands (n = 1), and the United States of America (n = 7).

Based on the analysis, the documents differed in these notable ways: Definition and role of an EC, the degree to which an EC is recognized for their role in the care of the resident and thus referred to as an essential care partner (ECP), the degree to which ECs are (re) integrated into the LTC setting is prioritized; response to community spread of COVID-19; visitation during an outbreak or if a resident is symptomatic; the reliance on principles of equity, diversity, and inclusion; and lastly, monitoring and improving the process. We discuss these in detail below.

Definition and Role of an EC

In the literature, an EC was often defined by her or his relationship and role. In Australia, an EC was defined as an individual who regularly and frequently visited the resident to provide care and companionship.[17,18] However, this Definition has faced criticism (described below under "equity"). Other documents described the role of an EC beyond basic care, highlighting the importance of an EC in (1) maintaining daily routines[17]; (2) decreasing the psychosocial impact of COVID-19[17,18]; and (3) advocating on behalf of the resident.[27,28] Other documents did not differentiate an EC from a general visitor and/or did not allow for physical contact with the resident, limiting her or his ability to provide care.[23]

ECs as Essential Care Partners

The degree to which ECs are recognized as ECPs differed among strategies. In Australia, ECs are recognized by LTC staff as partners in care and that relationship is outlined in the "Partnership Model."[17] For example, a partnership may include discussion around (1) times and days of visitation; (2) activities and care roles; and (3) handover and communication.[17] In Canada, key LTC interest groups also acknowledged ECs as partners in care as a key principle or guiding principle,[5] but this recognition was not seen at the level of the government (as it was in Australia). Those documents that did recognize ECs as ECPs included strategies to better engage ECs.[5,17,18]

(Re)integration of ECs Into the LTC Setting

All strategies to (re)integrate ECs included basic Infection Prevention and Control (IPAC) measures. More comprehensive strategies included a detailed induction process to outline expectations and ongoing training and education.[17] However, the degree to which ECs were (re)integrated into the LTC setting differed. In Australia, ECs were (re)integrated in the least restrictive way possible, meaning ECs were welcomed back into LTC homes regardless of the level of COVID-19 transmission in the community.[17] This differed from the approach used by Verbeek and colleagues[23] in the Netherlands, where they did not differentiate an EC from a general visitor and allowed visitors with physical distancing, which prevents caregiving.[23]

Responding to Community Spread of COVID-19

Although most documents highlighted the need for a dynamic process to assess and manage risk, 2 strategies outlined a tiered system.[18,30] Both of these strategies recognized that the risk of COVID-19 may change with the degree of community transmission. At the highest level of community spread, the Tiered Escalation model in Australia allowed ECs to visit with appropriate orientation and training in IPAC.[18] In comparison, at the highest level of community spread, the Safe Start model published by the Washington State Department of Health and Department of Social and Health Services prohibited indoor visiting.[30]

Table 1
Data Extraction Table

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
Australia Partnerships in Care: Supporting Older People's Wellbeing in Residential Care Aged Care Quality and Safety Commission[17]	To "provide information on supporting partnerships in care safely while COVID-19 remains an ongoing risk. It will assist aged care and establish new partnerships."	A partner is "a person who has a close and continuing relationship with the care recipients, such as a family member, loved one, friend or representative. They frequently and regularly visit a person living or staying in a residential aged care service to provide aspects of regular routine care and companionship to that person."	Government fact sheet Methodology not described	"Benefits of partnership in care: 1. Maintains the important contributions a visiting partner in care makes to the care, wellbeing and quality of life of the individual receiving care. 2. Supports and maintains important routines for residents, in particular those residents living with cognitive impairment including dementia. 3. Assists the partners in care to learn new skills and understand how to implement safe practices when visiting the service and providing care to consumers. 4. Decreases the psycho-social impacts associated with COVID-19 visitor restrictions, lockdown and isolation including loneliness, anxiety, boredom, fear and depression. 5. May prevent other common impacts of COVID-19 such as malnutrition, weight loss and/or physical deconditioning that are associated with visitor restrictions, lockdown and isolation. These impacts can quickly reduce quality of life and lead to adverse outcomes for older people in care."	1. "How to implement a partnership in care in your service: a. Develop a process with residents to support partners in care. Refer to the Aged Care Quality Standards for guidance and support to ensure that you keep your residents at the center of your decision making; their needs, values, and preferences should inform and shape the actions you take. b. Set up a detailed induction process for partners in care and outline expectations while undertaking partnership in care activities. As a minimum, this should include Work Health and Safety requirements, privacy, screening on arrival, and PPE use expectations. c. Schedule and deliver ongoing training and education to all partners in care including monitoring and supporting compliance with infection control practices. d. Develop a dynamic process for assessing and managing risks to consumers and to partners in care, for example the risk of COVID-19 transmission. Take into consideration individual vulnerabilities and that the risks may change with time and local circumstances. e. Develop a process for assessing how a partner in care arrangement may impact other individuals receiving care, and for minimizing that impact as appropriate. f. Implement a process for staff to engage with partners in care during visits. This should include a handover about the resident to outline activities undertaken since the last visit, any relevant observations or areas of concern.	Inequity—Identifying an ECP may come in response to a request from a resident or any other individual; it is not necessarily the responsibility of the facility. Inclusion—Resident must be at the center of the decision-making process and the agreed arrangement must align with the views, wishes, and preferences of the resident; however, the resident does not have the authority to assign an ECP.

(*continued on next page*)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
					g. Identify on-site areas that the partners in care can and cannot access during visits; consider what access is required to support care and infection control. h. Provide a mechanism for feedback from consumers, partners in care and staff, including self-assessment and continuous improvement. 2. How to implement individual partner in care arrangements: a. Identify which family members, loved ones, friends or representatives meet the Definition of a partner in care. (This may be done in response to requests from the resident or any of these individuals, or proactively by the service in discussion with the consumer where possible.) b. Arrange a comprehensive discussion regarding the partnership in care arrangements between the consumer, service and the partner in care. c. Document the agreed approach in detail. d. Ensure the agreed arrangement aligns with the views, wishes and preferences of the resident. e. Ensure the consumer and/or their substitute decision-maker consents to the agreement. f. Ensure the consumer and the partner in care understand that the arrangement is subject to renegotiation in response to Public Health orders or changing local COVID-19 situation and risks. g. Assess impacts on other individuals receiving care and implement appropriate mitigation strategies. For example, if a partner in care arrangement is being established for a consumer who shares a room with another consumer who does not want visitors,	

				strategies will need to be implemented that consider and accommodate the rights and interests of both consumers. h. Complete a risk assessment and ensure risks to consumer and to the partner in care are clearly explained to all parties. i. Establish a regular communication process with all partners involved in a partnership in care arrangement. j. Review the arrangements with the resident and partner in care based on the agreed timeframe."	
Visitation Guidelines for Residential Aged Care Facilities Australian Health Protection Principal Committee[18]	To provide "guidance for aged care providers on actions to be undertaken depending on the COVID-19 situation within the community." The intended audience is residential aged care providers."	ECP is "someone who has frequently and regularly visited a resident to provide aspects of care and companionship to that person. An ECP is not a casual visitor or visitor not providing an aspect of care or visitor who the resident does not want to have assisting in their care."	Government report Methodology not described	"Key principles: 1. AHPPC supports continuing efforts to proportionately implement appropriate infection prevention and control measures with residential aged care and for other vulnerable populations receiving aged care at home. 2. Jurisdictional health directives must be followed, including adherence to physical distancing, personal hygiene and other recommended IPAC measures. 3. AHPPC considers the maintenance of nutritional, physical and psychosocial wellbeing of residents in RACFs to be of vital importance, balanced with their personal welfare, and human rights. 4. AHPPC supports visitors (including family, friends, visiting health workers and support staff) to residents of aged care homes in the least restrictive manner possible, in line with the known or likely wishes and preferences of the older person/resident. 5. An ongoing and dynamic risk assessment should influence the level of limitation on visitation, the type of visitation restrictions implemented	"Guidelines related to visiting principles: All Tier's: IPAC education and information provision, physical distance, personal hygiene measures, and seasonal influenza vaccination in line with State/Territory directions Tier 1: Epidemic of no transmission or no locally acquired cases: No restriction Tier 2: Epidemic of jurisdictionally defined hotspots: Encouraged for ECPs– with appropriate orientation/training, visitor time limitation, location, and supervision limitation consistent with pre-COVID arrangements, no visitor age limit Tier 3: Epidemic of COVID-19 in the community: Encouraged for ECPs – with appropriate orientation/training, and in line with Principle 7 of the Industry Code Limitations based on State/Territory directions for visitor time, visitor number, visitor age and visitor location"	Equity—Special considerations should be given to preventing deconditioning for people living with dementia or other cognitive impairment which may make other activities directed at preventing deconditioning more challenging Exclusion—Resident does not have the authority to assign an ECP, but can decline one

(*continued on next page*)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
				and attendance by a resident to locations external to the residential aged care facility. 6. The dynamic risk assessment should be based on the current level of COVID-19 community transmission (both at the location of the RACF and the community of the visiting person) and only occur in a manner that is proportionate to the prevalence of community transmission. 7. The "Tiered Escalation" model should be utilized in determining the level of visitation and other restrictions required. 8. Aged care providers should be prepared to step-up and step-down based on local or State/Territory public health advice, direction from the Aged Care Response Centre within the relevant State or Territory, or their risk assessment at the local level. 9. The restrictions on entry, recommendations on entry to residential aged care, screening and management of staff and visitors and external excursions from residential aged care (for personal or health reasons) outlined in the policy. 10. The Industry Code on Visiting Aged Care Homes during COVID-19, should be followed. In particular, Principle 7 which deals with exceptional circumstances in which visitation should be allowed even during Tier 3. 11. State and Territory public health units have the ability for aged care providers (and where		

				relevant, community members) to be able to request consideration, on a case-by-case basis, of exceptions to relevant jurisdictional directions."		
Industry Code for Visiting Residential Aged Care Homes During COVID-19 Council on the Ageing[19]	To "provide an agreed industry approach to ensure aged care residents are provided the opportunity to receive visitors during the COVID-19 pandemic, while minimizing the risk of its introduction to, or spread within, a residential care home."	Not included, but complements the "Tiered Escalation model" outlined above	Key interest group policy guidance Methodology not described	"Principles: 1. At all three Escalation Tiers, providers will continue to facilitate visits between residents and visitors consistent with the Charter of Aged Care Rights and State or Territory Emergency and Health Directives. 2. During periods requiring Escalation Tier 2 or Tier 3 response, visits may occur in a variety of ways (such as in a resident's room, outside in a courtyard or a designated visiting area) and may be supplemented with additional ways to connect a resident and their visitors (such as utilizing technology, window contacts or balconies). 3. During periods of Escalation Tier 2 or Tier 3, aged care homes may be required to limit the overall number of people in a facility to meet physical distancing and hygiene requirements. 4. During all Escalation Tiers, the wishes and preferences of residents will be at the Centre of all decision making in relation to who visits them, and their choices will be sought and respected, unless the visitor is prohibited under state/territory directives. 5. At all three Escalation Tiers existing legislation and regulation continue to apply during COVID-19 including the Aged Care Act and its related Principles, the Aged Care Quality Standards, the Carers Recognition Act 2010 and Charter of Aged Care Rights.	"Rights: Providers— 1. To mitigate risk of infection by refusing entry to their home to anyone, or requesting that a person leave the premises, for any justifiable reason consistent with this Code. 2. To move into increased visitor restrictions when an outbreak (including non-COVID-19) occurs within the home, or local clusters in the surrounding suburbs and towns of the home occur or if there are other extraordinary circumstances that require it, and usage of such circumstances will be closely monitored. Residents and visitors— 1. Residents receive visitors and access aged care homes in accordance with the entry requirements and with the maximum frequency and length possible. 2. To receive timely and regular updates and information about what is happening in the Home, consistent across the whole resident population, and with increased frequency of communication local COVID-19 prevalence and transmission risk. 3. To maintain contact with their local community outside the home, including to participate in religious and cultural gatherings via alternate means such as online or phone. 4. To be provided with additional ways to connect such as window contacts, video conference or telephone calls in addition to a limited number of in-person visits. 5. To receive/deliver gifts, clothing, food and other items. 6. To transfer to other accommodation or an alternate residential aged care home, following clarification of any public health directives, resident's wishes and consideration of support needs. Responsibilities: Providers—	Equity— Additional considerations for: Residents who have a clearly established and regular pattern of involvement from visitors contributing to their care and support must continue to have these visits facilitated. Also, residents with a clear mental health issue—provision of support to maintain the mental well-being of the older person, where a serious mental illness is known or emerging and where the maintenance of social and family connection may contribute to relieving social and emotional distress for the resident. Inclusion—The wishes and preferences of residents will be at the center of all decision making in relation to who visits them, and their choices will be sought and respected, unless the visitor is prohibited under state/territory directives.

(*continued on next page*)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
				6. At all three Escalation Tiers, no visitor should attend an aged care home if they are unwell, have a temperature of greater than 37.5 degrees Celsius, history of fever, cough, sore throat, runny nose, shortness of breath or displaying any cold/flu, respiratory or COVID-19 related symptoms or if they have recently travelled from a designated hotspot town/suburb (as determined by States or Territories Health authorities). 7. During Escalation Tier 2 or Tier 3, there are circumstances which require additional consideration while maintaining visits for the following "social supports" circumstances: A. Residents who are dying should be allowed in-room visits from loved ones on a regular basis. B. Residents who have a clearly established and regular pattern of involvement from visitors contributing to their care and support (this could be daily or a number of times per week and, for example assisting a resident with their meals or with essential behavior support such as for people living with dementia) must continue to have these visits facilitated. C. Residents with a clear mental health issue - provision of support to maintain the mental wellbeing of the older person, where a serious mental illness is	1. Appropriately support staff in order to facilitate visits including in-room visits, in- person visits, by a resident's visitors, including written processes and procedures. 2. Ensure additional ways to connect such as video conference or telephone calls to compensate for limited visits. 3. To ensure that the knowledge of, easy access to, and cooperation/collaboration with OPAN advocates or other formal advocates are provided and that the legal representatives of residents (including Power of Attorneys, Guardians and Health Attorneys) are heard, and their substituted decisions are upheld where able and lawful. 4. Provide timely and regular updates to residents and their nominated representative/guardian/attorney including any relevant government directives. Proactive communication to occur to residents and families where an outbreak occurs, delivered consistently across the resident population. 5. To ensure all staff are vaccinated under State/Territory Directives and Australian Government Guidelines. 6. State/Territory health authorities have a responsibility to inform providers where there is a local cluster of COVID-19 near a home, and the home has a responsibility to follow State/Territory directions. Residents and visitors— 1. Not to visit when unwell or displaying any signs of a cold/flu, respiratory or COVID-19 symptoms. 2. To respond truthfully to COVID-19 screening questions asked by the home's staff. 3. To treat all staff with respect and courtesy, and to follow their instructions. 4. Contact the home before visiting, to secure a mutually convenient time.	

known or emerging and where the maintenance of social and family connection may contribute to relieving social and emotional distress for the resident.

8. During Escalation Tier 2, consideration should be given for more flexible approaches for Visits from family, families of choice and friends who travel extensive distances to visit the resident.
9. With all Escalation Tiers, visitors may be subject to procedures such as booking systems and screening procedures. This may have restricted length of visits during Tier 2 and Tier 3 to ensure as many people as possible can visit. A flexible and compassionate approach to visiting times should be utilized."
10. At all three Escalation Tiers, Residents have the right to continue to receive letters, parcels including gifts, non-perishable food and communication devices to the home.
11. During all Escalation Tiers, regular and responsive communication between families and the home will increase in circumstances where there are increased visitor restrictions.
12. During Escalation Tier 1 or Tier 2, residents can continue to use public spaces within the home, including outdoor spaces using physical distancing measures as required by COVID guidelines and within the constraints imposed by the layout of each home.
13. During all three Escalation Tiers, Residents right to access medical and related services (eg, repair of
5. To follow visiting requirements including providing evidence of up-to-date influenza vaccination, infection and prevention control measures such as washing hands, use of visiting windows, remaining in residents' rooms, or in designated areas and Social Distancing and Hygiene Requirements—as directed by the aged care staff."

(*continued on next page*)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
				hearing aids or glasses, urgent dental care, mental health support) will be maintained. 14. During Escalation Tier 1 or Tier 2 periods of preparedness escalation external outings and visits are permitted for residents and visitors where these can be conducted in a safe manner, noting these may not be permitted during Escalation Tier 3. 15. Providers will vary their own response in line with Escalation Tiers outlined by AHPPC.		
Canada Policy Guidance for the Reintegration of Caregivers as Essential Care Partners: Executive Summary and Report Canadian Foundation for Healthcare Improvement[5]	To "develop policy guidance to support a safe and consistent approach for reintegrating essential care partners back into healthcare facilities, long-term care and congregated care settings during a pandemic." The policy guidance was intended for "healthcare decision makers, notably system level policy makers and system leaders."	ECPs "provide physical, psychological and emotional support, as deemed important by the patient. This care can include support in decision making, care coordination and continuity of care. ECPs can include family members, close friends or other caregivers and are identified by the patient or substitute decision maker."	Key interest group policy guidance Developed "as part of a collaborative policy lab process that included policy decision-makers, health system leaders who implement policy, and the people who are impacted by policy decisions—providers, administrators, patients, families and caregivers."	"Key principles: 1. Differentiate between visitors and family caregivers as essential care partners 2. Recognize the value of caregivers as essential care partners 3. Ensure patients, families and caregivers have a voice in the development of policies related to visitors and essential care partners"	"Policy guidance: 1. Identification and preparation of essential care partners a. Develop mutual expectations of responsibilities: Ensure patients understand what an ECP is and are welcomed to identify their own ECPs; Establish process and roles to connect ECP with a staff point-person for consistent coordination b. Establish pre-entry preparation for ECP: Ensure consistent and ongoing information and education for ECPs regarding safety protocols required for entry c. Establish staff education to understand roles and safety protocols for ECPs: Ensure there is education and clear communication for staff regarding the role and value of ECPs and their safe re-entry d. Establish a rapid appeals process: Communicate a clear and transparent appeals process to patients and ECPs so concerns can be quickly raised and addressed 2. Entry into facility a. Establish a clearly communicated screening process: Implement a consistent	Inclusion—Ensures that key partners have a voice, including patients, families, and caregivers; Residents can identify their own ECP

					screening process with relevant, evidence-informed protocols and questions; Ensure clear communication regarding what is expected at screening; Create an opportunity for different methods of pre-entry screening and provide information on expected safety protocols b. Establish caregiver IDs for ECPs: Institute processes that clearly identifies ECPs; Connect these processes with supportive education for safety protocols and PPE processes c. Ensure ECPs are informed about existing and updated infection prevention and control protocols: Provide an opportunity for ongoing updates to ensure ECPs are aware of recent safety protocols and processes"	
Directive 3 for Long-Term Care Homes Under Ontario's Long-Term Care Homes Act, 2007 Ontario Ministry of Health[20]	Not reported	Essential visitor defined as "a person performing essential support services (eg, food delivery, inspector, maintenance, or health care services (eg, phlebotomy)) or a person visiting a very ill or palliative resident."	Government policy Methodology not reported	Not reported	"Managing visitors: At minimum visitor policies must: 1. Be informed by the ongoing COVID-19 situation in the community and the LTC home and be flexible to be reassessed as circumstances change. 2. Be based on principles such as safety, emotional well-being, and flexibility and address concepts such as compassion, equity, non-maleficence, proportionality (ie, to the level of risk), transparency and reciprocity (ie, providing resources to those who are disadvantaged by the policy). 3. Include education about physical distancing, respiratory etiquette, hand hygiene, IPAC and proper use of PPE. 4. Include allowances and limitations regarding indoor and outdoor visiting options. 5. Include criteria for defining the number and types of visitors allowed per resident when the LTC home is not in an outbreak, in accordance with Ministry of LTC and MSAA policies. When the LTC home is in an outbreak, only essential visitors are permitted in the LTC home. 6. Include screening protocols, specifically that visitors be actively	Not addressed in this document

(continued on next page)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
					screened on entry for symptoms and exposures for COVID-19, including temperature checks, and not be admitted if they do not pass the screening. 7. Include visitor attestation not to be experiencing any COVID-19 symptoms. 8. Comply with the LTC home's IPAC protocols, including donning and doffing of PPE. 9. Clearly state that if the LTC home is not able to provide surgical/procedure masks, no visitors should be permitted inside the LTC home. Essential visitors who are provided with appropriate PPE from their employer, may enter the LTC home. 10. Include a process for communicating with residents and families about policies and procedures including the gradual resumption of visits and the associated procedures. 11. State that non-compliance with the LTC home's policies could result in a discontinuation of visits for the non-compliant visitor. 12. Include a process for gradual resumption of general visitors that stipulates: a. Visits should be pre-arranged. b. Residents are permitted up to maximum two visitors at a time. c. Must only visit the resident they are intending to visit, and no other resident. d. Visitors should use a face covering if the visit is outdoors. If the visit is indoors, a surgical/procedure mask must be worn at all times. e. Visits are not permitted when: A resident is self-isolating or symptomatic, or an LTC home is in an outbreak, or the LTC home is located in a public health unit region where there is evidence of increasing/significant community transmission, ie, Orange (Restrict), Red (Control)	

					or Grey (Lockdown) levels in the provincial COVID-19 Response Framework: Keeping Ontario Safe and Open. Specify that essential visitors: 1. Be defined as including a person performing essential support services (eg, food delivery, inspector, maintenance, or health care services, (eg, phlebotomy)) or a person visiting a very ill or palliative resident. 2. Providing direct care to a resident must use a surgical/procedure mask while in the LTC home, including while visiting the resident that does not have COVID-19 in their room. 3. Who are in contact with a resident who is suspect or confirmed with COVID-19, must wear appropriate PPE in accordance with Directive #1 and Directive #5. 4. Are the only type of visitors allowed when: a. A resident is self-isolating or symptomatic, or b. An LTC home is in an outbreak, or c. The LTC home is located in a public health unit region where there is evidence of increasing/significant community transmission, ie, Orange (Restrict), Red (Control) or Grey (Lockdown) levels in the provincial COVID-19 Response Framework: Keeping Ontario Safe and Open."	
Resuming Visits in Long-Term Care Homes Ontario Ministry of Long-Term Care[21]	Provided "to support homes in implementing the requirements in Directive #3 to safely receive visitors while protecting residents, staff, and visitors from the risk of COVID-19."	For clarity, in addition to the Directive #3 requirement, an essential visitor may "include support workers and caregivers." A caregiver is a "type of essential visitor who is designated by the resident and/or their substitute decision-maker and is visiting to provide direct care to the resident (eg, supporting feeding, mobility, personal hygiene, cognitive stimulation, communication, meaningful connection, relational continuity and	Government policy Methodology not described	"Guiding principles: 1. Safety—Any approach to visiting must balance the health and safety needs of residents, staff, and visitors, and ensure risks are mitigated 2. Emotional well-being—Allowing visitors is intended to support the emotional well-being of residents by reducing any potential negative impacts related to social isolation 3. Equitable access—All residents must be given equitable access to receive visitors, consistent with their preferences and within reasonable	"Caregivers— 1. Caregivers must be at least 18 years of age 2. A maximum of 2 caregivers may be designated per resident at a time. The designation should be made in writing to the home. Homes should have a procedure for documenting caregiver designations. The decision to designate an individual as a caregiver is entirely the remit of the resident and/or their substitute decision-maker and not the home. 3. A resident and/or their substitute decision-maker may change a designation in response to a change in the: A. Resident's care needs that are reflected in the plan of care	Equity—All residents must be given equitable access to receive visitors, consistent with their preferences and within reasonable restrictions that safeguard residents Inclusion— Residents have the right to choose their designated caregiver and may change a designation in response to a change

(continued on next page)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
		assistance in decision-making)"		restrictions that safeguard residents 4. Flexibility—The physical/infrastructure characteristics of the home, its staffing availability, whether the home is in an outbreak and the current status of the home with respect to PPE are all variables to take into account when setting home-specific policies 5. Equality—Residents have the right to choose their visitors. In addition, residents and/or their substitute decision-makers have the right to designate caregivers"	B. Availability of a designated caregiver, either temporary or permanent Access to Homes and Outbreak Areas—Permitted as follows, subject to direction from the local public health unit: 1. Where the home is not in an outbreak: a. If the resident is not self-isolating or symptomatic, a maximum of 2 caregivers per resident may visit at a time b. If the resident is self-isolating or symptomatic, a maximum of 1 caregiver per resident may visit at a time 2. Where the home is in an outbreak, a maximum of 1 caregiver per resident may visit at a time 3. A caregiver may not visit any other resident or home for 14 days after visiting another: Resident who is self-isolating or symptomatic and/or home in an outbreak Screening— 1. Homes should ask caregivers to verbally attest to the home that they have tested negative for COVID-19 within the previous two weeks and not subsequently tested positive. Homes are not required to provide the testing. 2. Homes should ask caregivers to verbally attest to the home that, in the last 12 days, they have not visited another: Resident who is self-isolating or symptomatic and/or home in an outbreak 3. Prior to visiting any resident for the first time after this policy is released, the home should provide training to caregivers that addresses how to safely provide direct care, including putting on and taking off required PPE, and hand hygiene. The home should also provide retraining to caregivers, with the frequency of retraining indicated in the home's visitor policy	

4. The home's visitor policy should include guidance from the following Public Health Ontario resources to support IPAC and PPE education and training for visitors

Managing safe visits—

1. Homes may not require scheduling, or restrict the length or frequency, of visits by caregivers
2. Homes are not required to supervise visits

Non-adherence by visitors—

1. Responding to non-adherence:
    a. Provide strategies for supporting visitors in understanding and adhering to the home's visitor policy
    b. Recognize visits are critical to supporting a resident's care needs and emotional well-being
    c. Consider the impact of discontinuing visits on the resident's clinical and emotional well-being
    d. Reflect and are proportionate to the severity of the non-adherence
    e. Where the home has previously ended a visit by, or temporarily prohibited, a visitor, specify any education/training the visitor may need to complete before visiting the home again.
2. Ending a visit: Homes have the discretion to end a visit by any visitor who repeatedly fails to adhere to the home's visitor policy provided:
    a. The home has explained the applicable requirement(s) to the visitor
    b. The visitor has the resources to adhere to the requirement(s)
    c. The visitor has been given sufficient time to adhere to the requirements

Homes should document whether they have ended a visit due to non-adherence

3. Temporarily prohibiting a visitor: Homes have the discretion to temporarily prohibit a visitor in response to repeated and flagrant non-adherence with the home's visitor policy. In exercising this

(*continued on next page*)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
					discretion, homes should consider whether the adherence: a. Can be resolved successfully by explaining and demonstrating how the visitor can adhere to the requirements b. Is within requirements that align with instruction in Directive #3 and guidance in this policy c. Negatively impacts the health and safety of residents, staff and other visitors in the home d. Is demonstrated continuously by the visitor over multiple visits e. Is by a visitor whose previous visits have been ended by the home Any decision to temporarily prohibit a visitor should: 1. Be made only after all other reasonable efforts to maintain safety during visits have been exhausted 2. Stipulate a reasonable length of the prohibition 3. Clearly identify what requirements the visitor should meet before visits may be resumed 4. Be documented by the home Where the home has temporarily prohibited a caregiver, the resident and/or their substitute decision-maker may need to designate an alternate individual as caregiver to help meet the resident's care needs."	
Finding the Right Balance: An Evidence-Informed Guidance Document to Support the Re-opening of Canadian Nursing Homes to Family Caregivers and Visitors During the Coronavirus Disease 2019 Pandemic Stall and colleagues[22]	To support "a balanced, risk-mitigated re-opening of Canadian NH to family caregivers and visitors." Guidance specific to NH, but may be applied to other congregate settings.	Family caregiver is "any person whom the resident and/or substitute decision-maker identifies and designates as their family caregiver. As essential partners in care, they can support feeding, mobility, personal hygiene, cognitive stimulation, communication, meaningful connection, relational continuity, and assistance in decision-making."	Key interest group policy guidance Reviewed nursing home visitor national and international policies, consulted national and international experts, and heard from residents and their families to identify 6 core principles and planning assumptions	"Guiding principles: 1. Policies must differentiate between "family caregivers" and "general visitors" 2. Restricted access to visiting must balance the risks of COVID-19 infection with the risks of social isolation to resident health, well-being and quality of life 3. Visitor policies should prioritize equity over equality and be both flexible and compassionate 4. Governments, public health authorities, and	"Recommended, evidence-informed, and expert-reviewed visitor policies for family caregivers: 1. Defining a "family caregiver" a. Residents, substitute decision makers and their families should have the authority and autonomy to determine who is essential to support them in their care 2. Allowable number of designated family caregivers a. A resident may designate at least two family caregivers b. A resident may identify a temporary replacement if the primary designated family	Equity—Under extenuating circumstances, number of family caregivers should be flexible and residents may identify a temporary replacement if needed Diversity—Recognized the role of family caregivers in helping to "ensure that all residents receive culturally safe and appropriate care, especially for LGBTQ2S+ and Indigenous residents and/or those with language barriers. Inclusion—Recognized that residents have the sole authority and autonomy to

nursing homes must provide regular, transparent, accessible, and evidence-based communication and direction
5. Robust data related to re-opening nursing homes to family caregivers and general visitors should be collected and reported
6. A mechanism for feedback (from residents, family caregivers and visitors) and a process for rapid appeals should be established"

caregiver is unable to perform their role for a period of time
3. Allowable number of family caregivers in the nursing home at one time
    a. One family caregiver per resident should be allowed in the home at a time
    b. Under extenuating circumstances, this allowable number should be flexible
4. Allowable locations within the nursing home
    a. Family caregivers should have access to areas both outside and inside the home, but must maintain physical distancing from other residents and staff. Note, they should be provided with an individualized caregiver identification and/or badge, and must abide by all IPAC and PPE requirements and procedures.
5. Allowable access during a COVID-19 outbreak
    a. Family caregivers should still have access to the home during a COVID-19 outbreak, as long as: The family caregiver attests that they understand and appreciate they are entering a home under outbreak and may be at increased risk; they must be trained in IPAC procedures and proper use of PPE and abide by all outbreak-related policies
6. Allowable frequency and length of time for family caregiver presence
    a. No restrictions as long as it does not negatively impact the care of other residents or the ability of other family caregivers to provide care and support
7. Screening and testing requirements
    a. Family caregivers should be subjected to the same COVID-19 screening requirements as nursing home staff
8. IPAC and PPE requirements
    a. Family caregivers should receive an orientation and be educated and trained to follow the same IPAC and PPE requirements and procedures

determine who is essential to support them in their care.

(*continued on next page*)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
					b. Homes must maintain ample PPE supply c. Failure of family caregivers to comply with these procedures could be grounds for loss of their rights to participate in care as family caregivers, which should be appealable"	
The Netherlands Allowing Visitors Back in the Nursing Home During the COVID-19 Crisis: A Dutch National Study Into First Experiences and Impact on Well-being Verbeek and colleagues[23]	To examine how the Dutch guideline was "applied in the local context; the compliance to local protocols; and the impact on well-being of residents, their family caregivers, and staff."	Definition not provided; does not differentiate between types of visitors	Primary study Mixed-methods cross-sectional study, consisting of a questionnaire, telephone interviews, analyses of documentation (Eg, local visiting protocols), and a WhatsApp group N = 26 nursing homes (proportionally representative for the Netherlands)	"Pre-conditions for visitors: 1. Make arrangements with the NH on frequency and duration of the visit 2. One designated visitor is allowed per resident 3. Take personal hygiene measures (use of hand sanitizer at entrance, temperature check) 4. Visitors are spread throughout the day and week 5. Visits take place at least 1.5-meter (eg, 5 feet) distance, including from staff and other residents 6. Visitors should be free from COVID-19 symptoms 7. Visitors are obliged to wear a protective mouth mask for visiting residents who are difficult to instruct (eg, people with dementia) Preconditions for organizations: 1. Should observe the regulations and keep in perspective the well-being of residents and family 2. Sufficient PPE, thermometer assessment, and appropriate application of this 3. Strict hygiene protocol 4. Sufficient staffing 5. Sufficient test capacity by Local Health Authority"	During the first week: Residents that received a visit: 954 residents (57%) Locations that allowed visitors for essentially all residents: 21 locations (6 locations permitted visits for ≥80% residents, 15 locations permitted visits for 20% = 70%, but was limited primarily because of time needed to organize the logistics) Locations that did not allow visitors for all residents: 4 locations permitted visits for selected residents (eg, "those who needed it the most") Compliance with national guidelines, N = 25 (% of locations that complied): Only 1 visitor per resident: n = 25 (100) Visitors screened on active COVID-19 symptoms at the visit: n = 24 (96) Visitors' body temperature is measured: n = 22 (88) Visitors have to sanitize their hands: n = 25 (100) Visitors wear masks: yes, n = 14 (56); partly, n = 6 (24); no, n = 4 (16); missing, n = 1 (4) Visitors wear gloves: n = 6 (25) Visitors are supervised: yes, n = 6 (24); partly, n = 9 (6); no, n = 10 (40) Impact on well-being: Unanimously positive impact on residents, family, and staff Some felt it difficult for residents and family not to be able to touch each other and have physical contact New COVID-19 infections: No new COVID-19 infections were reported for the 26 participating nursing homes 3 weeks after visits were allowed	Not addressed in this document

United States of America Recommendations for Welcoming Back Nursing Home Visitors During the COVID-19 Pandemic: Results of a Delphi Panel Bergman et al[24]	To "generate consensus guidance statements focusing on essential family caregivers and visitors"	Definition not provided	To generate consensus statements, the authors used a modified 2-step Delphi process where consensus was defined as >80% of panel members who voted "agree" Panel members included 21 North American experts in post-acute and long-term care, ranging from clinicians to administrators (19%) to patient care advocates (29%): Female (67%); White (71%), African American (10%), and Asian (19%)	Delphi voting results: Round 1: 55/78 statements reached consensus (71% consensus) Round 2: 11/21 revised statements reached consensus (52% nonconsensus to consensus conversion) Persistent nonconsensus guidelines (regarding visiting guidelines and HCP): Visiting guidelines: 1. A negative COVID-19 test is not a requirement prior to visiting a nursing home (70% consensus); 2. Visitors who wish to visit a nursing home resident who is actively asymptomatic but for whom COVID-19 testing is pending or unknown should have an informed consent discussion with nursing leadership, demonstrate appropriate donning and doffing of PPE and agree to wear appropriate PPE during the visit (47% consensus) HCP: 1. Allow entry of all essential and nonessential health care personnel, contractors, and vendors with appropriate screening, physical distancing, hand hygiene, and face coverings. They would be subject to the same testing and surveillance requirements as the rest of the HCP (staff) cohort. Visitors including nonemployed caregivers and surrogate decision makers would be subject to the visitor guidelines (74% consensus); 2. The nursing home should consider a designated caregiver (or dedicated	Consensus statements were merged and expanded into guidance statements: 1. "Minimum criteria to welcome visitors: a. All staff, residents, and visitors engage in basic hand hygiene and physical distancing in public, shared spaces. b. All staff wear a medical-grade mask while in the NH. c. All residents and visitors wear a face covering when in shared, public spaces. If a resident or visitor does not own a face covering, one must be provided by the NH. d. The facility has sufficient disinfecting supplies and adequate PPE. e. A written isolation and cohorting plan is in place. f. A written screening and testing plan with adequate capacity for implementation is in place. g. A written contact tracing and outbreak investigation plan is in place. 2. Screening a. All persons entering the NH undergo the same entrance screening process, including a temperature check and answering an exposure and symptom questionnaire by a trained entrance screener. b. Visitors that do not comply with the screening procedure are not allowed to enter. 3. Visit logistics a. Visitors and volunteers can sign up to visit a resident for a defined time period using an electronic process. b. The NH maintains a sign-in log that includes contact information (name, phone number, email address) of visitors and volunteers to help with contact tracing in the event of an exposure.	Diversity—After review of the panel composition, a "decision was made to invite additional selected members to join in an effort to expand minority populations." Members were also representative of the larger industry (ie, not all current clinicians) Inclusion—Each resident or surrogate decision maker can choose an essential family care, who alongside a surrogate decision maker would have priority to frequently visit

(*continued on next page*)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
				support person, surrogate decision maker) an essential member of the health care team who would not be subject to visitor guidelines if resources (PPE, training, monitoring) are available at the time and the person is directly engaged in compassionate care to alleviate residents psychosocial stress as a result of isolation (79% consensus)	c. An NH may need to limit the number of indoor visitors to no more than 2 visitors at one time to allow physical distancing between visitor groups. d. Visit frequency and the number of visitors an NH is able to accommodate would depend on the physical space, availability to visit outdoors, and PPE availability. 3. Infection prevention strategies a. Visitors must be guided to the designated visit area to limit interactions with patient care areas, staff, or other residents. b. Gloves and a gown with associated hand hygiene are required if visitors wish to engage in limited physical contact with a resident, such as hugging, hand holding, or direct resident care such as assistance with meals. The nursing home must provide gloves and gowns for this purpose. 4. Location a. The NH should designate areas for indoor and outdoor visits. Ideally the visits would occur outside, conditions permitting. b. Indoor areas should be accessible without walking through a resident care area, must be disinfected between scheduled visits, and should be large enough to facilitate physical distancing between visit groups. 5. Essential family caregiver a. An NH should allow each resident or surrogate decision maker to choose essential family caregivers who, along with the surrogate decision maker, would have priority to frequently visit a resident, for	

					example, to provide complex care, aid in feeding, or redirect and reassure those residents living with dementia who have responsive behaviors. 6. Symptomatic residents Visiting a resident with or without symptoms who has a positive, unknown, or pending COVID-19 test result requires the following steps: a. The visitor must participate in an informed consent discussion with leadership regarding the risks of potential exposure to COVID-19 and whether they outweigh the benefits of a visit. Additionally, visitors should be counseled to understand the COVID-19 test status and encouraged to wait for a pending test result to return prior to a scheduled visit. b. The NH must provide education and training so that the visitor can demonstrate appropriate donning/doffing of PPE, including a mask, gowns, gloves, and possibly a face shield. c. The visitor must agree to wear the recommended PPE during the visit and follow all IPAC procedures within the NH. 7. Compassionate care, end-of-life visits a. The NH should make every attempt possible to work with visitors of residents who are seriously ill, receiving care focused on comfort, and approaching end-of-life. Specifically, facilities may waive the visitor limits, offer extended hours, and offer an in-person room visit to help facilitate the psychosocial well-being of the resident and family members."	
Managing Visitors Centers for Disease Control and Prevention[25]	To "provide guidance to healthcare facilities on the management of visitors to reduce	Caregivers are defined as "parents, spouses, other family members or friends without formal healthcare training."	Government report Methodology not reported	Not reported	"When visiting COVID-19 patient is essential: a. Visitors to areas where patients with COVID-19 are isolated should be limited to essential visitors	Inclusion—Strongly discourages those at high risk for severe illness from being an essential caregiver

(*continued on next page*)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
	the risk of transmission of SARS-CoV-2." Document provided by CDC and "intended for use in non-US healthcare settings."				such as those helping to provide patient care and/or caring for pediatric patients. Limit to one visitor/caregiver per patient with COVID-19 at a time b. Visits should be scheduled to allow enough time for screening, education, and training of visitors c. Visitors should be assessed to determine risks to their health. Visitors who are at high risk for severe illness from COVID-19, such as older adults and those with underlying medical conditions, should be strongly discouraged d. Movement of visitors in the healthcare facility should be restricted. Visitors should only visit the patient they are caring for and should not go to other locations in the facility e. Facilities should provide education on appropriate PPE use, hand hygiene, limiting surfaces touched, social distancing, and movement within the facility f. Facilities should make sure that visitors understand the potential risks associated with providing care to patients with COVID-19, especially for visitors at high risk for serious illness from COVID-19 and those who are primary caregivers and have extended contact with patients g. Visitors should not be present during aerosol-generating procedures or during collection of respiratory specimens h. Facilities should consider the need to conduct active screening for visitors with potential exposure to SARS-CoV-2 due to a breach in IPAC protocol"	
Nursing home visitation—COVID-19 Centers for Medicare & Medicaid Services (CMS)[26]	To provide "new guidance for visitation in nursing homes during the COVID-19 PHE. The	CMS does not distinguish between these types of visitors and other visitors.	Government policy Methodology not reported	"Core principles of COVID-19 infection prevention: 1. Screening of all who enter the facility for signs and symptoms of COVID-19	"Facilities should accommodate and support indoor visitation, including visits for reasons beyond compassionate care situations, based on the following guidelines:	Inclusion— Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being,

guidance below provides reasonable ways a nursing home can safely facilitate in-person visitation to address the psychosocial needs of residents."

(eg, temperature checks, questions or observations about signs or symptoms), and denial of entry of those with signs or symptoms
2. Hand hygiene (use of alcohol-based hand rub is preferred)
3. Face covering or mask (covering mouth and nose)
4. Social distancing at least six feet between persons
5. Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (eg, use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
6. Cleaning and disinfecting high frequency touched surfaces in the facility often, and designated visitation areas after each visit
7. Appropriate staff use of PPE
8. Effective cohorting of residents (eg, separate areas dedicated to COVID-19 care)
9. Resident and staff testing conducted as required

Additionally, visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life."

a. There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing;
b. Visitors should be able to adhere to the core principles and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children;
c. Facilities should limit the number of visitors per resident at one time and limit the total number of visitors in the facility at one time (based on the size of the building and physical space). Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors; and
d. Facilities should limit movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Visits for residents who share a room should not be conducted in the resident's room.

NOTE: For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.

Facilities should use the COVID-19 county positivity rate, found on the COVID-19 Nursing Home Data site as additional information to determine how to facilitate indoor visitation:

Low (<5%) = Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits)

Medium (5%-10%) = Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits)

High (>10%) = Visitation should only occur for compassionate care situations according to the core principles of COVID-19 infection prevention and facility policies

Facilities may also monitor other factors and support their quality of life

(*continued on next page*)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
					to understand the level of COVID-19 risk, such as rates of COVID-19-Like Illness visits to the emergency department or the positivity rate of a county adjacent to the county where the nursing home is located. We note that county positivity rate does not need to be considered for outdoor visitation. We understand that some states or facilities have designated categories of visitors, such as "essential caregivers," based on their visit history or resident designation. CMS does not distinguish between these types of visitors and other visitors. Using a person-centered approach when applying this guidance should cover all types of visitors, including those who have been categorized as 'essential caregivers.'"	
Essential Caregiver Guidance for Long-Term Care Facilities Minnesota Department of Health[27] and Nebraska Department of Health[28]	To provide guidance for the LTC facilities to implement an EC program	An EC "could be a person who was previously actively engaged with the resident or is committed to providing companionship and/or assistance with activities of daily living."	Government policy guidance. Methodology not reported.	"Role of essential caregiver: 1. Detect concerns and advocate on behalf of the resident; 2. Observe and communicate important details and changes in a resident's condition/behavior; 3. Assist the resident in management of complex or critical information; 4. Provide emotional support and help honor the resident's personal values and preferences of care; 5. Alleviate caregiving tasks for staff and providers; 6. Preserve and promote quality of life for residents; 7. Help promote/maintain a sense of continuity, identity, and autonomy for residents."	"Guidance for facilities electing to designate ECs: 1. Establish policies and procedures for how to designate and utilize an EC 2. Consult facility's Administrator, Director of Nursing, Social Services Director, or other designated facility staff to help determine who meets the criteria of an EC. 3. Resident must be consulted about their wishes to determine whom to designate as the EC. 4. Residents may express a desire to designate more than one EC based on their past involvement and needs. 5. Work with the resident and EC to identify a schedule of up to three hours per day, or until caregiving tasks are completed, for the EC to be in the facility. 6. Ensure scheduling of EC visits considers numbers of EC in the building at the same time. The facility may establish time limits as needed to keep residents safe. 7. Utilize the EC to provide care and emotional support in the same manner as prior to the pandemic, or in whatever manner necessary,	Equity—Residents may express a desire to designate more than 1 EC based on their past involvement and needs. Diversity—The facility must allow evening and weekend visits that accommodate the EC, who may be limited by work or child care barriers Inclusion—Resident must be consulted about their wishes to determine whom to designate as the EC

					as resident health care or psychological conditions may have changed. 8. Designate a central point of entry where the EC signs in and is actively screened for symptoms of COVID-19 prior to entering the building, in the same manner as facility staff. 9. The EC must wear all necessary PPE while in the building (minimally eye protection and face mask), and must perform frequent hand hygiene. 10. The facility must educate the EC on how to don/doff necessary PPE appropriately. 11. The EC must inform the LTC provider if they develop a fever or symptoms consistent with COVID-19 within 14 days of a visit to the resident. 12. The facility must allow evening and weekend visits that accommodate the EC who may be limited by work or child care barriers. 13. Direct the EC to provide care in the resident's room, or in facility-designated areas within the building. 14. The EC must maintain social distancing of at least 6 feet with staff and other residents while in the building. 15. The EC should not take the resident out into the community except for essential medical appointments. 16. The EC must not be allowed to visit a resident during a resident's 14-day quarantine, and must not visit when a resident is positive for COVID-19 or symptomatic, unless the visit is for compassionate care. 17. The LTC facility may restrict or revoke EC status if the EC fails to follow social distancing, use of PPE, or other COVID-19 related rules of the facility"	
Guidance for long-term care facilities to establish essential caregiver programs and to allow visits Missouri Department of Health and Senior Services[29]	To provide guidance "for facilities wanting to establish an EC program and/or allow general visits to occur either inside or outside the facility."	EC is "an individual, including clergy members, who has been given consent by the resident, or their guardian or legal representative, to provide health care services or assistance with activities	Government policy guidance Methodology not reported	Not reported	"Guidelines: 1. One EC may be designated for each resident. One additional caregiver may be designated if that individual is a clergy member. Only one EC should be present at any given time. 2. EC should complete facility-designated infection prevention and	Diversity—An additional caregiver may be designated if that individual is a clergy member

(*continued on next page*)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
		of daily living to help maintain or improve the quality of care or quality of life of a facility resident. Care or services provided by the EC is included in the plan of care or service plan for the resident and may include assistance with bathing, dressing, eating, and/or emotional support."			control training, including proper PPE and mask use, hand hygiene, and social distancing. 3. Consider having EC sign a consent form acknowledging completion of the facility-designated infection prevention and control training, an understanding of the facility's visitation and infection prevention and control policies, and the risk created by frequency and duration of close contact. 4. EC should be screened upon arrival and only be allowed entry if the screening criteria is met. 5. EC should inform the facility if they develop a fever or symptoms consistent with COVID-19 within fourteen days of a visit to the resident. 6. The facility should maintain EC logs noting the names of EC, who they visited, staff that assisted the EC during the visit, dates of visit, and contact information in the event of a subsequent COVID-19 outbreak among staff or residents. 7. EC should utilize full PPE, including a gown, mask, and gloves at all times while in the facility. This PPE may be provided at the facility's expense. 8. The facility should work with the EC to establish a mutually agreeable schedule that addresses the facility obligations, including the numbers of EC in the building at the same time, and is person-centered. 9. After attempts to mitigate concerns, the facility should restrict or revoke visitation if the EC fails to follow infection prevention and control requirements or other COVID-19-related rules of the facility. 10. A facility may stop EC visits if the facility has a resident test positive for COVID-19, or has a staff person that tests positive for COVID-19 if the staff person was in the facility in the ten days prior to the positive test, until it has been fourteen days	

				since the last facility acquired COVID-19 positive case. 11. EC should maintain a social distance of at least six feet with staff and other residents and limit movement in the facility."		
Safe Start for LTC Recommendations and Requirements: NH and Intermediate Care Facilities for Individuals With Intellectual Disabilities Washington State Department of Health and Department of Social and Health Services[30]	To present a "phased safe start plan for licensed and certified long-term care facilities and agencies."	An "ESP could be an individual who was previously actively engaged with the resident or is committed to providing companionship and/or assistance with activities of daily living."	Government policy guidance Methodology not reported	"Safe start for facilities: Phase 1: Designed aggressive infection control during periods of heightened virus spread in the community and potential for healthcare system limitations, which may include factors such as staffing, hospital capacity, PPE and testing. Heightened virus spread (high COVID-19 activity) is defined as >75 cases/100,000 for two weeks Phase 2: Meeting the following criteria: 1. Moderate transmission is occurring in the community. Moderate transmission is defined as 25-75 cases/100,000 population for two weeks. 2. 28 days have passed since the last positive or suspected resident/client or staff case was identified in the home OR any timeline required by the LHJ, whichever is greater. 3. Adequate staffing levels are in place. 4. The facility performs and maintains an inventory of PPE to assure at least a 14-day supply using the CDC PPE burn rate calculator. Phase 3: Meeting the following criteria: 1. Minimal transmission is occurring. Minimal transmission is defined as 10-25 cases/100,000 population for two weeks. 2. 28 days have passed since the last positive or suspected resident or staff case was identified in the home OR any timeline required by the LHJ, whichever is greater. 3. Adequate staffing levels are in place.	"Visitation for nursing home mitigation steps: Phase 1: Indoor visitation prohibited, except for: 1. Compassionate care situations restricted to end-of-life and psycho-social needs Phase 2: Indoor visitation prohibited, except for: 1. Compassionate care situations restricted to end-of-life and psycho-social needs 2. If a resident is unable to participate in outdoor visits, and is unable to utilize remote visitation through technology, they may have one ESP who visits in the facility up to once daily: (A) Under limited and controlled conditions, coordinated by the facility, in consideration of social distancing and universal source control; and (B) ESPs are screened upon entry and additional precautions are taken, including social distancing and hand hygiene Phase 3: 1. All residents have the ability to have limited visitations 2. Facility policy will describe visitation schedule, hours and locations 3. Infection control practices, including social distancing (at least 6 feet apart) 4. Facilities may limit the number of visitors for each resident 5. Preference for outdoor visitation opportunities 6. Visitors must sign in, including contact information and the log must be kept for 30 d. Phase 4: Resume regular visitation"	Equity—Only residents who are unable to participate in outdoor visits or unable to utilize remote visitations may have an ESP Inclusion—Residents must be consulted about their wishes to determine whom to designate as the ESP Note, psycho-social needs not defined, may have been left intentionally broad

(*continued on next page*)

Table 1 (*continued*)

Title, Author, and Year of Publication	Aim or Purpose	Definition of an EC	Study Design, Methodology and/or Population	Guiding Principles	Policy or Policy Recommendations	Equity, Diversity, and Inclusion
				4. The facility performs and maintains an inventory of PPE to assure at least a 14-day supply using the CDC PPE burn rate calculator. 5. The facility performs and maintains an inventory of disinfection and cleaning supplies for residents and clients. 6. There is assurance by the LHJ that local hospital(s) have the capacity to accept referrals/transfers. 7. The facility/home is capable of cohorting residents with dedicated staff in the case of suspected or positive cases OR is able to transfer positive cases to a COVID-19 positive facility for care and recovery OR in the case of small homes, there is a plan in place for managing both positive and negative cases while mitigating the spread of infection. Phase 4: Meeting the following criteria: 1. Sporadic transmission is occurring in the community. Sporadic transmission is less than 10 cases/100,000 population for two weeks. 2. 28 days have passed since the last positive or suspected resident or staff case was identified in the home OR any timeline required by the LHJ, whichever is greater; 3. The facility/home has adequate staffing levels in place 4. The facility performs and maintains an inventory of PPE to assure at least a 14-day supply using the CDC PPE burn rate calculator 5. The facility performs and maintains an inventory of disinfection and cleaning		

supplies for residents and clients
6. There is assurance by the LHJ that local hospital(s) have the capacity to accept referrals/transfers;
7. The facility/home is capable of cohorting residents with dedicated staff in the case of suspected or positive cases OR is able to transfer positive cases to a COVID-19 positive facility for care and recovery OR in the case of small homes, there is a plan in place for managing both positive and negative cases while mitigating the spread of infection."

AHPPC, Australian Health Protection Principal Committee; CDC, Centers of Disease Control and Prevention; ESP, essential support person; HCP, health care personnel; IPAC, infection prevention and control; LHJ, local health jurisdictions; MSSA, multisector service accountability; OPAN, Older Persons Advocacy Network; PHE, public health emergency; PPE, personal protective equipment; RACF, residential aged care facility;

Visitation During an Outbreak or if a Resident Is Symptomatic

Visitation during an outbreak differed among strategies. In Ontario, Canada, and Australia, visits by ECs are permitted when a resident is self-isolating, symptomatic, and/or if an LTC home is in an outbreak[18,20] and is a practice supported by a key interest group.[22] In the United States, policies have allowed LTC facilities to stop essential visits if either a resident or staff member tests positive for COVID-19.[29] However, in an article by Bergman and colleagues, it was concluded that facilities are encouraged to permit visitation, but with conditions (eg, informed consent).[24] The Centers for Disease Control and Prevention[25] recommended that visitors to areas where patients with COVID-19 are isolated are limited to only essential visitors. Such guidelines that do not permit essential visitation during an outbreak are argued to be overly restrictive.[22]

Principles of Equity, Diversity, and Inclusion

Equity

In the LTC setting, principles of equity recognize that residents have the right to the needed care and level of care. Equity was a stated guiding principle or was otherwise evident in most documents. Some documents acknowledged the need for special considerations under certain circumstances, such as the need for an additional EC, the need to switch an EC, or an emerging mental health issue.[18,19] In Canada, it is noted that residents may change their designated caregiver if there is a change in their care needs.[21] Inequity was also evident. In Australia, it was outlined that identifying an EC may be done in response to a resident/EC request or done proactively by the care home.[17] However, residents may not understand what an EC is or that they may select one, which may lead to inequitable access. In Australia, the Industry Code (which is an agreed on approach or standard by key stakeholders) was aimed to ensure a consistent approach, but more importantly recognized that residents have the right to receive visitors.[19]

Diversity

In the LTC setting, principles of diversity recognize that (1) residents are a diverse population and policies and guidelines should reflect that nature and (2) input on policies and guidelines should include representation from all levels of the LTC sector. Diversity, as a guiding principle, was not commented on in the literature; however, elements of diversity are seen in some of the documents. For example, principles of diversity included recognizing that ECs have a role in helping to "ensure that all residents receive culturally safe and appropriate care"[22] and allowing an additional caregiver to be designated if the first designated EC is a clergy member.[29] Other documents recognized the need for a flexible and compassionate approach, such as allowing evening and weekend and allowing indoor visiting. Interestingly, one document highlighted the future need to take into consideration residents' care preference and allow, for example, resident groups that are more risk-accepting to have increased social interactions.[24] Lastly, in one document an effort was made to have a diverse panel that was representative of the LTC sector and population by (1) including clinicians, administrators, and patient care advocates and (2) inviting selected members of minority populations to join.[24] The above was done to ensure all views were represented.

Inclusion

In the LTC setting, inclusion recognizes that residents should be included in the decision-making process (eg, designating an EC). In some documents, an EC is identified by the resident.[5,22,24] In Australia, a seemingly paradoxical approach is followed where an EC is determined by the facility, with the resident said to be at the center of the decision-making process. In this case, ECs are designated when they are seen to be individuals who have clearly established relationships and have

frequently or regularly visited the residents.[17,18] However, only having ECs that have a clearly established relationship may be limiting, as Stall and colleagues[22] point out that this approach "fails to recognize that some individuals may be willing and able—or need to—assume caregiving responsibilities." In the United States, one document stated that visitors "at high risk for severe illness from COVID-19, such as older adults and those with underlying medical conditions, should be strongly discouraged."[25] Although Stall and colleagues[22] highlighted the importance of input from residents and ECs in policy guidance or development, no document actually included this.

Monitoring and Improving the Process

Given that the COVID-19 situation is relatively unprecedented, there is a need to be flexible and compassionate in the approach to (re)integrating ECs into LTC homes. Most documents acknowledge the need for feedback on the policy or guidelines implemented from residents, ECs, and LTC staff. More comprehensive strategies highlight the need for clear and transparent communication on an appeal process and the need for a rapid appeal process.[5,17] Another important aspect to consider is how an essential visit may impact others receiving care (eg, a resident who shares a room with another resident). As mentioned in one document,[17] the rights and interests of both residents should be considered. Such feedback is an important process for continuous improvement.

Discussion

Different strategies have been implemented in several countries to (re)integrate ECs into the LTC setting. In the absence of research evidence, these strategies were often based on a range of expert opinions. As a result, guidelines and policies varied widely. As this review only identified 2 primary research studies, rather than provide evidence-based recommendations, we provide promising practices based on a comparison of the different expert opinion group strategies we found in this review to (re)integrate ECs into the LTC setting. These promising practices are intended to better inform policy and to ensure an equitable, diverse, and inclusive strategy.

We, the authors, propose the following promising practices:

1. ECs must be differentiated from other visitors and recognized for their essential role in providing care to residents and contributing positively to the physical, mental, and social well-being of residents.

Policies and guidelines that do not differentiate ECs from other visitors fail to recognize the essential role that they play in the resident's well-being.[23,26] Although other visitors can play an important role in socialization, ECs play an essential role in providing care to the residents, and thus, their (re)integration into the LTC homes should be prioritized over other visitors. Recognizing the essential role of ECs is a guiding principle and a key policy recommendation.[5,17–22,24,25,27–30]

2. ECs must be accorded the additional recognition as ECPs to provide high-quality, resident-centered care.

ECs should be recognized meaningfully as partners in providing high-quality, resident-centered care.[5,17] To be clear, LTC homes are responsible for providing care in the absence of the EC. Just as an EC should not replace the role of LTC staff, LTC staff cannot replace an EC. According to one document,[17] by recognizing ECs as ECPs, care arrangements can be made collaboratively between staff and ECPs.

3. ECs must be welcomed into the LTC setting in the least restrictive manner possible, including when there is community spread of COVID-19 and during an outbreak or if a resident is symptomatic.

LTC settings are encouraged to welcome ECs into the LTC setting in the least restrictive manner possible provided that they have the appropriate resources to do so.[18] This is best supported by a tiered framework that is dynamic and flexible.[18,30] With the tiered framework, the degree of restriction is proportional to the degree of local community transmission. At the highest level of community transmission, ECs should still be welcomed into the LTC setting.[18,20,22,24,25] We argue that the practice of strongly discouraging ECs at high risk of COVID-19 from visiting could marginalize ECs and cause the isolation of LTC residents. Rather, we recommend an informed discussion be had where the risks and benefits of their visit are discussed.[18,20,22,24,25]

4. Equity, diversity, and inclusion must each be considered when identifying a strategy to (re)integrate ECs into the LTC settings.

Principles of equity, diversity, and inclusion should each be an important guiding principle when implementing any policy or strategy to (re)integrate ECs into the LTC setting. Such principles are at the heart of high-quality, resident-centered care. Strategies to (re)integrate ECs into the LTC setting should recognize that resident needs differ.[18,19] Resident diversity and the role of ECs are important considerations with which to provide both culturally safe and appropriate care.[22] Although not commented on in the literature reviewed here, these are key to providing care to certain subpopulations, such as minority residents and/or those with language barriers who may have additional mental and emotional vulnerabilities. Lastly, we strongly believe that residents should have the sole authority to designate ECs.[5,21,22,24] That authority should not lay with the LTC home and should not be based on established relationships or visiting practices. The EC should reflect the values, preferences, and needs of the resident, which may change with time.[22]

5. Any approach to (re)integrate ECs into the LTC setting should include a clear and transparent appeal process where any concern could be rapidly responded to and addressed.

Given that the COVID-19 pandemic is unprecedented, we agree with Stall and colleagues[22] and advocate for an approach that is both flexible and compassionate. At minimum, the approach should include an appeal process that can rapidly respond to and address concerns from residents, ECs, families, and staff.[5,22] Such a process should be clearly documented and accessible to all. The process should be flexible and compassionate, considering all individuals involved, including the rights and interests of other residents. Such feedback is important for self-assessment and continuous improvement.[5]

6. A need exists for research evidence to better inform policy.

There is an urgent need for primary research evidence to better inform policies concerning ECs in LTC homes. Future research into the values, preferences, and needs of both residents and essential caregivers is needed. Best practice should include both residents and essential caregivers as key stakeholders in the decision-making process. As strategies are implemented to (re)integrate ECs into LTC settings, there is a need to examine (1) the impact on related outcomes (eg, physical, mental, and social well-being of residents); (2) how the (re)integration of ECs in the LTC setting is experienced by residents, ECs, families, and LTC staff; and (3) how the different strategies for (re)integrating affect COVID-19 transmission within an LTC facility. Such evidence can inform policy and pave the path as we experience future phases of the COVID-19 pandemic and prepare for new infectious disease threats in the future.

Limitations

This rapid review identified different strategies used to (re)integrate ECs into the LTC setting. There are a number of limitations that must be considered. First and foremost, the COVID-19 pandemic is rapidly evolving and policies and guidelines are rapidly changing. Unfortunately, this review does not capture any information or

guidance around experiences or policies post-vaccination. Second, given that COVID-19 documents are published in a vast array of forums, it is possible that some evidence was missed. Lastly, while the aim was to provide evidence-based recommendations, a lack of research evidence meant that the promising practices provided draw from various expert opinion groups. However, the equity, diversity, and inclusion lens add value to the current body of literature.

Conclusions and Implications

The COVID-19 pandemic is rapidly evolving. As ECs are reintegrated into the LTC setting, it is important to consider existing strategies from an equity, diversity, and inclusion lens. There is a need for primary research to examine the impact of such reintegration policies and guidelines on the residents, ECs, LTC staff, and COVID-19 transmission within an LTC home. Until such evidence is available, expert opinion will drive best care practices.

References

1. Sepulveda ER, Stall NM, Sinha SK. A comparison of COVID-19 mortality rates among long-term care residents in 12 OECD countries. J Am Med Dir Assoc 2020;21:1572–1574.e3.
2. Sanford AM, Orrell M, Tolson D, et al. An international Definition for "nursing home". J Am Med Dir Assoc 2015;16:181–184.
3. Fisman D, Bogoch I, Lapointe-Shaw L, et al. Risk factors associated with mortality among residents with coronavirus disease 2019 (COVID-19) in long-term care facilities in Ontario, Canada. JAMA Netw Open 2020;3:e2015957.
4. Gardner W, States D, Bagley JD. The coronavirus and the risks to the elderly in long-term care. J Aging Soc Policy 2020;32:310–315.
5. Canadian Foundation for Healthcare Improvement. Better together: reintegration of family caregivers as essential partners in care in a time of COVID-19. https://www.cfhi-fcass.ca/docs/default-source/itr/tools-and-resources/bt-re-integration-of-family-caregivers-as-essential-partners-covid-19-e.pdf?sfvrsn=5b3d8f3d_2. Accessed March 21, 2021.
6. Hartigan I, Kelleher A, McCarthy J. Visitor restrictions during the COVID-19 pandemic: An ethical case study. Nurs Ethics 2021;28:1111–1123.
7. Comas-Herrera A, Salcher-Konrad M, Baumbusch J, et al. Rapid review of the evidence on impacts of visiting policies in care homes during the COVID-19 pandemic. LTCcovid.org; 2020.
8. Hwang TJ, Rabheru K, Peisah C, et al. Loneliness and social isolation during the COVID-19 pandemic. Int Psychogeriatr 2020;32:1217–1220.
9. Simard J, Volicer L. Loneliness and isolation in long-term care and the COVID-19 pandemic. J Am Med Dir Assoc 2020;21:966–967.
10. Belanger L, Bussieres S, Rainville F, et al. Hospital visiting policies – impacts on patients, families and staff: A review of the literature to inform decision making. J Hosp Admin 2017;6.
11. Moher D, Stewart L, Shekelle P. All in the family: systematic reviews, rapid reviews, scoping reviews, realist reviews, and more. Syst Rev 2015;4:183.
12. Dobbins M. Rapid Review Guidebook: Steps for Conducting a Rapid Review. National Collaborating Centre for Methods and Tools. https://www.nccmt.ca/tools/rapid-review-guidebook. Accessed January 1, 2021.
13. Tricco AC, Antony J, Zarin W, et al. A scoping review of rapid review methods. BMC Med 2015;13:224.
14. Tricco AC, Garritty CM, Boulos L. Rapid review methods more challenging during COVID-19: commentary with a focus on 8 knowledge synthesis steps. J Clin Epidemiol 2020;126:177–183.
15. Glaser BG. The constant comparative method of qualitative analysis. Soc Problems 1965;12:436–445.
16. Hewitt-Taylor J. Use of constant comparative analysis in qualitative research. Nurs Stand 2001;15:39–42.
17. Australian Government: Aged Care Quality and Safety Commission. Partnerships in care: Supporting older people's wellbeing in residential care. https://www.agedcarequality.gov.au/sites/default/files/media/acqsc_partners_in_care_factsheet_final.pdf. Accessed March 29, 2021.
18. Australian Government: Department of Health. Visitation guidelines for residential aged care facilities. https://www.health.gov.au/sites/default/files/documents/2021/02/coronavirus-covid-19-national-aged-care-guidance-aged-care-visitation-guidelines.pdf. Accessed April 2, 2021.
19. Council on the Ageing. Industry code for visiting residential care aged homes during COVID-19. https://www.cota.org.au/wp-content/uploads/2020/12/Industry-Code-File-20112020.pdf. Accessed April 2, 2021.
20. Ontario Ministry of Health. Directive #3 for long-term care homes under the Long-Term Care Homes Act, 2007. https://health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/directives/LTCH_HPPA.pdf. Accessed March 29, 2021.
21. Ontario Ministry of Long-Term Care. Resuming visits in long-term care homes. https://www.health.gov.on.ca/en/pro/programs/ltc/docs/covid-19/mltc_visitor_policy_20200909_en.pdf. Accessed April 2, 2021.
22. Stall NM, Johnstone J, McGeer AJ, et al. Finding the right balance: an evidence-informed guidance document to support the re-opening of Canadian nursing homes to family caregivers and visitors during the coronavirus disease 2019 pandemic. J Am Med Dir Assoc 2020;21:1365–1370.
23. Verbeek H, Gerritsen DL, Backhause R, et al. Allowing visitors back in the nursing home during the COVID-19 crisis: a Dutch national study into first experiences and impact on well-being. J Am Med Dir Assoc 2020;21:900–904.
24. Bergman C, Stall NM, Haimowitz D, et al. Recommendations for welcoming back nursing home visitors during the COVID-19 pandemic: results of a Delphi panel. J Am Med Dir Assoc 2020;21:1759–1766.
25. Centers for Disease Control and Prevention. Managing visitors. https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/hcf-visitors.html. Accessed March 29, 2021.
26. Centers for Medicare & Medicaid Services, Department of Health and Human Services. Nursing Home Visitation - COVID-19. https://www.cms.gov/files/document/qso-20-39-nh.pdf. Accessed April 2, 2021.
27. Minnesota Department of Health. Essential caregiver guidance for long-term care facilities. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltccaregiver.html. Accessed March 29, 2021.
28. Nebraska Department of Health. Essential caregiver guidance for long-term care facilities. https://dhhs.ne.gov/Documents/COVID-19-Long-Term-Care-Essential-Caregiver-Guidance.pdf. Accessed March 29, 2021.
29. Missouri Department of Health and Senior Services. Guidance for long term care facilities to establish essential caregiver programs and to allow visits. https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/pdf/visitation-guidance.pdf. Accessed March 29, 2021.
30. Washington State Department of Health and Department of Social and Health Services. Safe start for long term care recommendations and requirements: nursing homes and intermediate care facilities for individuals with intellectual disabilities. https://www.governor.wa.gov/sites/default/files/LTC%20Safe%20Start%20NH-ICF-IID.pdf. Accessed March 29, 2021.

Supplementary Material 1

Search Strategy

To search the academic and gray literature, the following search strategy combined the keywords: (I) "Long-term care" OR "LTC" OR "Nursing home*" OR "Charitable home*" OR "Home for the aged" OR "Assisted living" OR "Congregate living centre" AND (II) "Essential care*" OR "Designated care" OR "Visito*" OR "Caregiver*" OR "Carer*" AND (III) "COVID" OR "COVID-19" OR "SARS-CoV-2" OR "2019-nCov" OR "2019 novel coronavirus" OR "SARS" OR "Severe acute respiratory syndrome" OR "H1N2" OR "Pandemic" OR "Epidemic." Medical subject headings [MeSH terms] were untagged and automatically mapped to the MeSH vocabulary when appropriate.

The search strategy was intentionally broad to increase the sensitivity to the databases. The strategy was determined in consultation with a research librarian. Documents that were identified in the search were exported into the software Covidence (www.covidence.org) for article screening.

Steps outlined in the Rapid Review Guidebook by the National Collaborating Centre for Methods and Tools:

Step 1: Define a practice question

The research question that guided the rapid review was:

I. How have essential caregivers (ECs) been (re)integrated into the long-term care (LTC) setting?

In addition to the primary research question, the review also aimed to examine the following:

II. What were the key and guiding principles for policy?
III. To what extent are contextual factors and principles of equity, diversity, and inclusion considered in reintegration policy?

Step 2: Search for research evidence

To search the academic and gray literature, the following search strategy combined the keywords: I) "Long-term care" OR "LTC" OR "Nursing home*" OR "Charitable home*" OR "Home for the aged" OR "Assisted living" OR "Congregate living centre" AND II) "Essential care*" OR "Designated care" OR "Visito*" OR "Caregiver*" OR "Carer*" AND III) "COVID" OR "COVID-19" OR "SARS-CoV-2" OR "2019-nCov" OR "2019 novel coronavirus" OR "SARS" OR "Severe acute respiratory syndrome" OR "H1N2" OR "Pandemic" OR "Epidemic." Medical subject headings [MeSH terms] were untagged and automatically mapped to the MeSH vocabulary when appropriate.

The above search strategy was used to search the following academic databases: PubMed, Scopus, EMBASE, CINAHL, and WHO COVID-19 repository (GOARN).

The search strategy was intentionally broad to increase the sensitivity to the databases. The COVID-19 repository was used at the suggestion of Tricco and colleagues to ensure that relevant articles, not captured in electronic databases, were captured. The strategy was determined in consultation with a research librarian. Documents that were identified in the search were exported into the software Covidence (www.covidence.org) for article screening.

Step 3: Critically appraise the information

As this review only identified evidence from 1 primary research study and methodology was often not described, we cannot provide evidence-based recommendations.

Step 4: Synthesize the evidence

Data extraction included aim or purpose and intended audience, Definition of an EC, study design, methodology and/or population, primary outcomes or guiding principles, policy or policy recommendations, and principles of equity, diversity, and inclusion. The data extraction was conducted by the second reviewer (L.P.) and verified by the first reviewer (K.T.). It was piloted on 3 documents and then adjusted upon discussion with the third reviewer (A.K.). To analyze the data, the evidence was considered in its entirety and careful consideration across the documents was used to identify key themes.

Step 5: Identify applicability and transferability issues for further consideration during the decision-making process

Although the aim was to provide evidence-based recommendations, a lack of research evidence meant that the promising practices provided here are mainly from various expert-opinion groups.

At the suggestion of Tricco and colleagues, our team worked closely with decision makers to interpret the rapid review results.