# 4 ACTIVITIES AND ENGAGEMENT
## Avoiding Isolation and Loneliness

### How Do We Keep People Wanting to Be Alive? by Colleen Knudson

In residential long-term care, the focus was on keeping residents physically safe. This was dictated by closing facilities to the community, wearing PPE, stopping group activities and communal dining, limiting visitors, and enforcing strict infection control. The knowledge that seniors with comorbidities were at extremely high risk of dying from COVID frightened us. We were terrified of possibly bringing the virus into the community, of being the person who opened the doors for illness and death to those in our care. We had all seen the news broadcasts with the footage of nursing homes across the nation going into lockdown, the few staff still in the buildings burnt out and drowning in grief. The weight of that possibility was crushing, and then the staffing crisis joined the pandemic. They were a formidable pair.

Nurses, CNAs, and other long-term care facility staff left the healthcare field in droves. Staff were schooling children at home, working double shifts, and navigating personal health issues. The addition of watching those in their care decline pushed many to quit their jobs and stay at home. The possibility of carrying the virus to your home or facility during the pandemic was a heavy burden.

Most staff isolated themselves from their friends and family; missing the birth of newborn babies, loved ones passing, weddings, showers, graduations, holiday gatherings, and other events. This isolation was challenging for staff, but doubly so for residents. Many of our residents are in the last years of their lives. They have a limited number of celebrations left to experience. Missing these events was incredibly painful for them and emphasized their distance from family. A FaceTime call or Zoom to join the events was sometimes a blessing, and other times it just amplified the anger that they could not be together with their loved ones. A significant reduction in residents' abilities to be in person with their loved ones jump-started the decline.

While staff isolated themselves, we could at least travel back and forth between our homes and jobs. The residents had only their facility, their room. Many residents need physical assistance to get outdoors or to another area in the building. With a staffing shortage and residents fearing COVID, many stayed in their rooms daily. Humans are not meant to isolate; we are social creatures, with our wellness directly correlating with the number and strength of our relationships. The pandemic reflected this, as residents' well-being declined without their usual daily engagements. Residents who were used to being out of their room multiple times a day for meals and activities were now coming out maybe once a day or not at all.

As an activity professional in an assisted living community, my job is to engage people in purposeful and meaningful activities that create a good quality of life. The new reality was figuring out how to do this with limited resources, including fewer staff members, smaller budgets, less time, facility closing, and quarantines. As the days went on, we began to see changes in our residents. They were sleeping later, often napping, losing weight, moving less, and sometimes not wanting to get out of bed. Others were repeatedly tearful, confused, and anxious, needing more time and attention from staff to feel safe and healthy.

This decline was devastating for a team on the edge of burnout. Many residents' increased emotional and physical needs, while the residence was short-staffed, were highly challenging. Seeing those in your care continue to decline despite your exhaustive efforts creates a feeling of helplessness, guilt, and failure. Our attempts to be more than caregivers, to be family, friends, beauticians, and pastors, were not enough to stop the depression and anxiety of many in our care. As the well-being of residents continued to decline, despite extensive efforts from staff, we began to ask ourselves whether the cost of physical health and safety was worth the mental deterioration of those in our care. How could we assist those in our care to *want* to be alive in their new reality? Physical existence meant nothing to them without purpose and quality of life.

Staff went back to discussions of what gives life meaning: comfort, connection, culture, joy, and purpose. Residents were giving up because they lost sight of, and access to, what was most important to give. Our Life Enrichment team focused on resources we had to bring back purpose and connection in residents' lives. We reached out to our community, volunteers, donors, and local schools.

### *Weight Loss*

Many residents were feeling depressed and moving much less, which meant they were not hungry. Many were no longer interested in meals

without eating in a communal dining setting. For residents diagnosed with dementia or Alzheimer's, there was no longer someone eating opposite them to provide mirroring and cueing. More independent residents were used to going to the grocery store every week. They missed having fresh produce and bakery items.

We initiated food and treat carts weekly to provide calorie-dense and favorite items. Carts were purchased and decorated in various themes to replace group activities to provide enjoyment, reminiscing, and sensory stimulation for residents. Staff had the opportunity to dress to match the

**Illustration 4.1.** Staff member serving cupcakes door to door (PowerPoint slide 61). Photo credit: Attic Angel Assisted Living and Memory Care.

theme, which provided great opportunities for conversation. We reminisced with residents about summer ice cream treats, Oktoberfest, tailgating, baking, and other joyful memories.

There was also a weekly happy hour cart, which was such a hit that residents began asking about the cart at breakfast! The mix of decorating themes, reminiscence, and sensory stimulation with each food item, resulted in most residents participating and greatly assisted in combating weight loss. The carts gave the residents something to look forward to and strengthened the relationships between residents and staff.

With decreased staffing, no communal dining, and no family visitors, some residents in our memory care unit took longer to eat meals and had reduced intake during meals. We worked closely with our student interns, who completed the majority of their internships virtually, to eat meals virtually with residents who benefited from mirroring and socialization for engagement during meals. This intervention was highly successful, so we also offered this to the residents' family members. The iPad was set across from the resident, allowing them to mirror and engage with the person on-screen.

For residents who had relied on weekly grocery shopping, we set up a variety of interventions. We established scheduled days/times for drop-offs. During these hours, family and friends could drop off any items for their loved ones. Residents could also place weekly grocery orders with staff. Staff communicated the items to volunteers who would virtually place the orders, pick them up, and deliver them during drop-off. Last, we turned our trishaw into a farmers market cart. Each week, Food Ser-

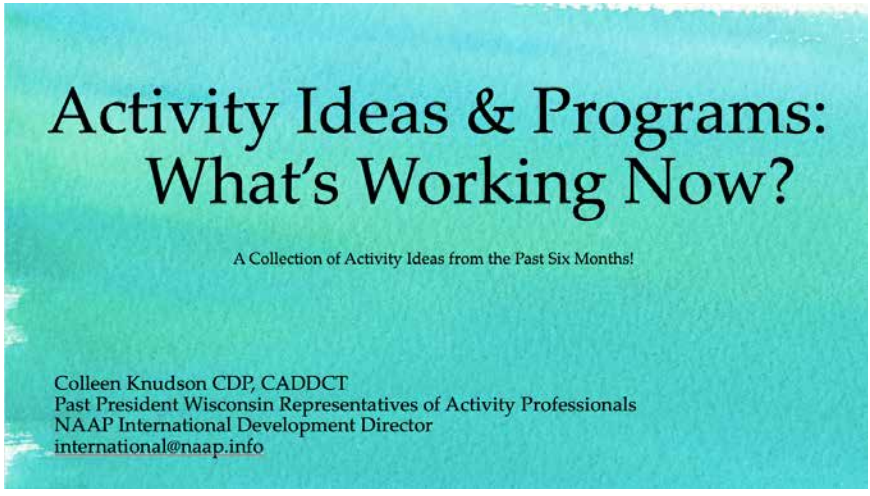


**Illustration 4.2.** What's Working Now PowerPoint slide.

vices would work with me to load the trishaw with fresh produce, baked goods, milk, and other items to be sold and delivered to our independent apartments. Residents were aware of the days/times that the cart would be out, and I stopped by each room for orders and delivery.

Other key issues of concern during the height of the pandemic that we focused on as activities professionals include decreased movement, isolation, and boredom. A list of activities and ideas for each of these categories follows and details for implementation are included here.

Decreased Movement

- In-house TV channel: Exercise, seated yoga, seated kickboxing
- Virtual internships: two of our caregivers completed a virtual internship with us for their university coursework
- Student Interns created exercise videos, instructional art, and other programs for our internal channel
- Student Interns created exercise stations outside in the gardens and walking path
- Active sports in hallway/resident doorways (e.g., golf and bowling)
- Walking
- Explore the building and grounds
  - Art Walk
  - Wellness Bingo
  - I Spy and Scavenger Hunts

Isolation

- Types of visits offered: one-on-one, hallway, outdoor
- Video visits with family and friends (Zoom, Skype, FaceTime)
- iPad and CD players/CDs
- Intergenerational interactions via technology: Classroom visits with follow-up mailings
- Student Onterns: Social bingo, Pictionary, and Wheel of Fortune
- Student Onterns: Spent a lot of time chatting with residents over Zoom, reading books, making art projects, playing games, and eating meals
- Family social via technology: Virtual Mother's Day tea, Zoom book club
- Community pals: Telephone calls, letters, artwork, cards, crafts
- Chaplain Class titled "Quarantine Coping Skills": Grounding, resiliency, grief and lament, meditation and connection (e.g., provided Angel crochet bookmarks, finger labyrinths, and prayer flags)
- Karaoke, hallway minstrels
- Overhead music with daily inspirational quote

- Spreading hope and cheer: Resident ambassador outdoor walk and signaling
- Acts of kindness: Heart messages
- Outdoor plexiglass visits, window visits, booth visits, car parades: Decorations/gifts/desserts
- Dog pen pals
- Mini whiteboards for communication and reminders

Boredom

- Independent activities: Room supplies
- Happy Heart Hunt
- Positive word collage
- Internet/app brain games
- Learn something new
  - Prerecorded exercise classes
  - Internal channel, CDs, DVDs, links
- Outdoors: Cookouts, concerts, staff parades, animal parades, dog parades

Staff Appreciation

- Posters
- Yard signs
- Outdoor decorations
- Heart trails
- Chalk drawings

> "They [administrators and other staff] say, 'Oh, we are doing a great job.' But to me it doesn't seem like it's a good job, because I think they're [residential long-term care residents] lonely as all get out and need the interaction, but everybody's scared." (P51)

> "Almost every resident in every level of care, no matter their age or ability, everyone's mental health, mental health and physical functioning, because they can't go to exercise, they can't get out and about to go walk, they really. . . They're struggling in every aspect right now. Lots of loneliness and lots of boredom." (P13)

These are quotes taken from our interviews with activities coordinators in residential long-term care communities during the early days of the pandemic who witnessed firsthand the isolation and loneliness of residents. Isolation has proven to be a defining feature of COVID-19 for everyone living in lockdown conditions across the globe, but especially those in residen-

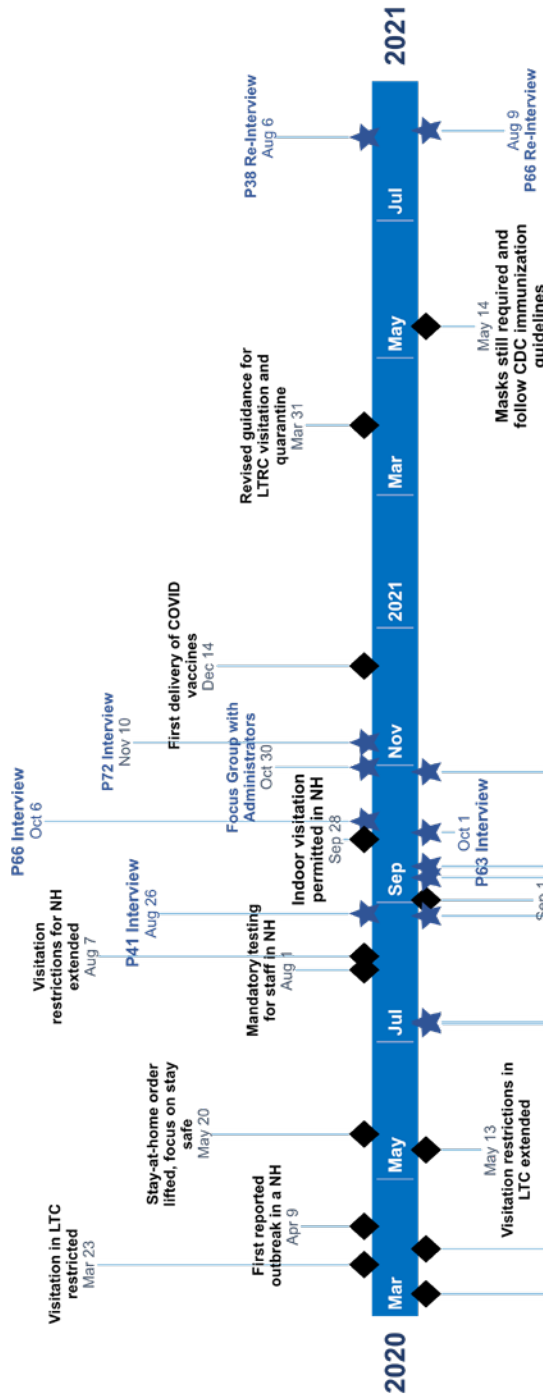


**Figure 4.1.** Timeline of Interviews Quoted in Chapter 4.

tial communities, older Americans fearful of leaving their homes because of the differential rates of morbidity and mortality for their demographic, and those no longer able to receive services with their peers at congregate sites. This chapter focuses on how frontline workers tackled isolation with a special emphasis on the experiences of activities coordinators and others who are normally tasked with engaging older Americans to prevent social isolation during non-pandemic times.

Social isolation is defined as the objective state of having few social relationships or infrequent social contact with others, while loneliness is a subjective feeling of being isolated (Wu 2020). In the United States, approximately one-quarter of community-dwelling older adults are considered to be socially isolated, and 43 percent of them report feeling lonely (National Academies of Sciences, Engineering, and Medicine 2020). Studies have found that social isolation and loneliness are major risk factors that have been linked with poor physical and mental health status, including increased blood pressure, heart disease, obesity, diminished immune system functioning, depression, anxiety, poorer cognitive functioning, increased risk of Alzheimer's disease, and mortality (DiNapoli, Wu, and Scogin 2014; Nicholson 2012). Social isolation has been associated with an approximately 50 percent increased risk of developing dementia, a 29 percent increased risk of incident coronary heart disease, and a 32 percent increased risk of stroke (National Academies of Sciences, Engineering, and Medicine 2020). We need to be cognizant that the social isolation resulting from efforts to decrease the spread of COVID-19, at the same time increased the risk of these negative outcomes, potentially having a profound impact on the health and well-being of older adults who were in lockdown (Wu 2020).

In this chapter we share the observations made by workers regarding the physical and mental decline they witnessed during the pandemic. These are important insights to capture as we heard of and bore witness to the devastating impact isolation had and continues to have on older Americans in need of long-term care. We interviewed twenty-one workers who focus on activities and engagement in residential long-term care communities and home and community-based programs where they work. We present the experiences and adaptations made by workers trying to engage older Americans in an effort to prevent decline, isolation, and boredom. Their narratives highlight the need for creativity and flexibility in the kinds of services provided as policies changed and affected the activities that were available and the subsequent limitation in regard to opportunities for engagement. Other themes identified include the power and challenges of technology and the need for effective communication. We begin with the observations made by workers regarding the physical and mental decline of the older adults they were caring for during the pandemic.

**Table 4.1.** Residential Long-Term care Activities Professionals and Home and Community-Based Workers Involved in Engagement.

| Participant # | Position | Credentials | Experience | Location | Age |
|---|---|---|---|---|---|
| 11 | Program Coordinator | BA-Health and Physical Education | 11 years | Memory care assisted living | 61 |
| 38 | Chaplain | MA-Divinity, Continuing Education | 9 years | CCRC | 58 |
| 41 | Activities Director | CNA, some college, activities course | 16 years | Assisted living | 48 |
| 43 | Community SW | BA, MSW, LCSW | 4 years | County | 49 |
| 49 | Program Director | BA-Business Admin, CDP* | 8 years | Adult day care | 55 |
| 50 | Director | BA-Business Admin, Gerontology Certificate | 20 years | Senior center | 60 |
| 51 | Life Engagement Director | BA-Criminology and Sociology | 6 months | Assisted living | 61 |
| 52 | Director, Sr. and Adult Programs | BA-Journalism and Spanish | 5.5 years | Senior enrichment program | 49 |
| 54 | Executive Director | BA-Business Administration | 21 years | Adult day care | 70 |
| 55 | Social Services Program Specialist | BSW | 3 years | Senior center | 59 |
| 57 | Recreation Coordinator Senior Services | MSW, MPA | 16 years | Senior center | 64 |
| 61 | Program Director | MA-Gerontology | 6 years | Senior center | 32 |
| 64 | Recreation Specialist | BA-Sociology, Gerontology minor | 2 years | Senior center | 28 |
| 66 | Executive Director | BA-Psych, MA-Gerontology | 20 years | Adult day health | 49 |
| 70 | Intake SW | BA-Sociology, Gerontology minor | 3 years | Department of Social Services | 50 |
| P71 | CNA | BSN, MSW | 3 years | Adult day health | 57 |
| P72 | Family Resource Manager | BA-Sociology, MA-Counseling, CNA | 4 years | Dementia day health | 56 |
| P73 | Agency Director | BA-Psychology and Equine Management | 9 years | Home care | 60 |
| P74 | Life Enrichment Manager | BS-Science, CNA | 2 years | Memory care assisted living | 27 |
| P75 | Co-owner | CNA | 9 years | Medical home care | 40 |
| P76 | Consultant | MHA | 18 years | Home care | 43 |

*CDP = Certified Dementia Practitioner

**Illustration 4.3.** Staff member and alpacas visiting residents through window (PowerPoint slide 87). Photo credit: Attic Angel Assisted Living and Memory Care.

## Physical and Mental Decline Due to COVID

Concerns for safety led to extensive isolation of residents living in residential long-term care and older adults living in the community since the beginning of the coronavirus pandemic. The impact that social isolation was having on both staff and the older adults they care for was a key finding that emerged beginning with the interviews with regional services providers and advocates in Phase 1 of our research. These concerns were repeated in the observations made by frontline workers regarding the physical and mental decline they witnessed during the pandemic. A nurse practitioner in a residential care environment explained:

> I'm just getting frustrated, I think, because I feel like this is not a sustainable way to handle this type of issue. And this is not going away, and it won't be the only virus that affects people like this, and . . . this is not gonna disappear. And so, I feel like those conversations . . . need to be had about "how are we going to handle this in a sustainable way that is not affecting, I think, the mental health of everyone?" (P10)

As discussed in chapter 2, the social lives of residents living in congregate care changed dramatically overnight. All aspects of their lives were

profoundly impacted when these communities were shuttered and residents were forced to stay in their rooms. Family visits ended, congregate dining was suspended, and socializing was dramatically limited. These changes had a major impact on this population, which led to noticeable physical and mental decline. One activities director in an assisted living community described the isolating environment residents were experiencing during the lockdown:

> For residents, of course, it's boring for them. And of course, it's isolation. It's isolation from their families, isolation from something simple like eating lunch. . . . You're eating lunch, and dinner, and breakfast in your room every day on a little table. It comes in a Styrofoam box. You're not having the dining room experience and at eighty and ninety years old, you want the dining. . . . You want to go in the dining room and see people. And you wanna get up and put your clothes on every day, and put some lipstick on and go out and see the world. You just don't wanna be isolated. (P41)

This activities director identified the negative impact of closing dining on residents who customarily ate together in the dining room, which was also experienced by those who were accustomed to eating at congregate dining sites, or adult day and healthcare centers. In addition, group activities in residential long-term care were severely limited, and residents were isolated in individual rooms while participants of community-based programs were now isolated at home. For residents in residential long-term care, family and friends were not able to visit, so the staff were often the only people they saw in person.

Caregivers in home and community-based programs continuously affirmed that physical and mental decline occurred as a result of the isolation brought on by COVID-19. For those in their care who survived, they felt it was too soon to tell whether this decline could potentially be reversed when older adults were able to be reunited with friends and family, and returned to their senior centers, adult day care and day health centers, or other places they gathered for community and engagement. While a family resource manager at a private adult day program acknowledged the decline in some of her clients, she did speak of some reversal of this decline in one participant once virtual programming started. However, she remained skeptical when pressed as to whether she believed the negative effects would be long- term for others, and that was difficult for her to come to terms with. She stated that while the center was closed,

> we started seeing people virtually and people had declined. One participant is now at home because our four hours a day wasn't working for her daughter who was working full time. So she ended up bringing a caregiver into

> the home and [the participant] ended up being virtually every day with us. But she and her caregiver join together virtually and so that's a resource for them. . . . The depression, and all of that, had her just totally withdrawn when the virtual started and it [virtual programming] brought her back. . . So we have seen decline, significant decline, and we've seen people come back. (P72)

They still believed there had been some irreversible decline due to the isolation, which they and other caregivers found very troubling.

Relatedly, well over a year after the shutdown, in a follow-up interview, an executive director of an adult day health program shed some light on this issue while demonstrating that the element of the unknown still existed and was difficult for the caregivers. When asked whether they had seen any reversal of the physical and mental decline they had spoken of in their initial interview, this participant answered:

> I don't know that I have seen improvements. Now, initially, when they came back, we might have seen some, but we're a year out now. I don't know that I can say that I have seen improvements recently, but most of them have dementia, which is progressive. . . . It was much easier a year ago after being closed for three months. That was dramatic, that was a dramatic decline for so many people. (P66)

Caregivers in both residential long-term care and home and community-based services talked about the impacts of the long isolation. One registered nurse (RN) who worked as a CNA had the following to say in reference to explaining the large number of older adults who had died during the time their adult day healthcare program was closed:

> I had a little sixty-some-year-old Down syndrome lady who passed during that time. Somebody told me, she said, "I think she must have just died of a broken heart." Because she lived in the facility, full time, but she came to us during the day for an outing, and her family got her out. And so she couldn't come to us, nobody could come in and see her, and she. . . I think she might have felt like she was being punished, "why can't I, why can't. . ." And then she passed. (P71)

Grace, the chaplain we met in the Introduction to this book, also described a similar situation with regard to "the correlation between people who were living this isolated life and people whose COVID symptoms maybe weren't that bad, but still it took them on out because they were already just emotionally fragile just from the isolation" (P38). The decline that these caregivers and staff noted among the older adults they care for was a concern felt most directly by the activities professionals and community-based program staff tasked with engaging this population.

**Illustration 4.4.** Program participants involved in planting outside with a staff member. Photo credit: Michele D. Allgood, program director of Gracious Living Adult Day and Health Care Center Corporation.

Next, we focus on the evolving and transitioning of approaches to activities and explicit challenges to maintaining engagement that occurred in residential long-term care before turning to the experiences in home and community-based care. We present these separately as there were particular differences and challenges in efforts to maintain engagement between those in residential care and those shuttered in their homes in the community.

## Activities and Engagement in Residential Long-Term Care

At the beginning of the pandemic, when residents were restricted to their rooms, activities staff creatively developed in-room and hallway activities. For example, residents remained in their doorways to play hallway bingo or participate in exercise groups. Mobile carts with activities were introduced to distribute individual activities to residents including puzzles, books, and coloring and word-find activities. As the lockdown restrictions were eased, activities professionals added small-group and outdoor activities, weather permitting. These included, for example, chair yoga and exercise classes in

small groups or pods. They had parades outside and socially distanced activities like water balloons and water guns. One activities coordinator shared: "So we've come a long way, and I am actually really proud of the ways we've adapted and the technology I have learned to do and I am not as afraid of now. So there are some positives" (P38). These professionals showed great creativity and flexibility in their efforts to engage their residents. Another participant described using a giant blow-up bowling set she purchased that residents could play in the foyer two at a time. Activities were shifted to the hallways and porches when the weather made outdoor activities possible.

While engagement of residents living in residential long-term care is often viewed as solely the responsibility of activities professionals, there are opportunities for engagement in every interaction by those providing care. As one activities director explained, their special care community for people living with dementia considers engagement a part of the responsibilities of all staff members:

> We make it clear to our staff, whether it's CNA, dietary, that we are here for the residents. . . . So we're not asking that they engage the residents in a thirty-minute program, but we do encourage them to take the time, five minutes, seven minutes, ten minutes, out of their schedule, here and there, to engage the residents in something that perhaps they've connected with that resident. And it could be sitting down and coloring, it could be singing a song, it could be just taking a walk with them, a stroll outside. So, it's all hands on deck. (P11)

During COVID it became particularly important for all staff members to focus on engagement with every resident and client they came in contact with, especially when dining was shifted to in-room service. The culmination of changes that led to isolation meant that older Americans needed to be engaged in more one-on-one activities. This added stress and anxiety for the already exhausted staff. An activities coordinator discussed the emotional challenges over the long period of time:

> I think in the beginning, because it was just all so new, and I knew that we needed to do all that we could do to make sure that we were keeping the residents healthy and ourselves, it wasn't so so bad. I just knew what was in front of us, and I knew what we needed to do, but as time has passed, just that every day of having to deal with this, to continue managing it, it hasn't been easy. . . I think it became a challenge for me to do the things that we do here to make sure that they, the residents, are staying healthy. (P11)

While this anxiety and exhaustion was experienced by nearly all frontline staff, some individuals had more challenges than others, which was

often determined by access to resources. Availability of technology was a key component of care during the pandemic that could either facilitate or inhibit the ability to care for residents. Some residential care communities were able to quickly create and stream original programming into individual rooms while others resorted to using individual caregivers' personal phones to video call residents' families. Communication for residents was essential to their well-being and access to technology framed the experiences of staff in terms of being able to assist in connecting families with their loved ones who were quarantined inside their rooms or residential communities.

Staff noted that the lack of family visitors increased their workload because before COVID many family members assisted in providing care, engagement, and dining support. Staff were quickly charged with facilitating "visitation" and fostering communication between residents and their family members. In-person visitation pivoted first to window visits, then outdoor porch visits. Much of the communication between residents and their families utilized technology including cell phones, FaceTime, and Zoom, which had to be set up and facilitated by activities staff and sometimes

**Illustration 4.5.** Sensory activity with physical distancing and plexiglass divider. Photo credit: Michele D. Allgood, program director of Gracious Living Adult Day and Health Care Center Corporation.

CNAs. Later in the pandemic, outdoor and then indoor visits were allowed, but these all had to be monitored by the staff. One activities coordinator stressed the challenges of communicating effectively with residents' family members with limited access to sufficient technology, in order to keep them informed and reassure them of residents' well-being. At the same time, it was crucial to foster adequate communication and engagement for the residents. The coordinator explained:

> I'm still asking for a second iPad 'cause I can't stress, keeping in contact with family members, I support that. I want them [residents] to be able to stay in contact with the "outside world," is what I call it. And I've requested that, and I think they [administration and corporate] finally clued into the one [iPad] that I have is kinda old and we need two. And they've [administration and corporate] tuned into that. (P41)

We now turn to the unique challenges faced by staff working in home and community-based programs during the pandemic. The centrality of technology and communication are themes that emerged as essential in both models of care and did directly impact the outcomes for older Americans during the COVID-19 pandemic.

## Maintaining Engagement in Home and Community-Based Programs

As discussed in chapter 3, most senior centers, as well as adult day care and day health programs, closed in March 2020, as advised by the county and advisory boards following state guidelines. One exception was a private adult day and healthcare center whose director explains her decision-making and experience in the essay at the beginning of chapter 3. Most programs quickly turned to phone contact with their participants and virtual programming. Similar to residential care staff, community-based staff demonstrated incredible creativity in pivoting to virtual programming and providing a range of opportunities to help engage clients who were now restricted to their homes and often isolated from family and friends. For example, Kellin Smith, the bus driver we heard from in chapter 3, engaged with his clients when he delivered home delivered meals. He was able to discern how they were handling the pandemic and report to his supervisors on what kinds of additional needs they had.

The in-home service providers proved to be quite malleable to the emerging needs of their clients and continued to go into the homes to provide care for any client who was willing to have them come. One home care provider

explained how they proceeded to continue to provide in-home care after just a couple of weeks while checking with staff daily about their health. The available staff were able to continue to provide services to clients who were willing to have them come into their homes. Most home-based clients and their families wanted to continue to receive services as a way to avoid loneliness while meeting their everyday needs. Engagement was possible with home care and personal care aides who were available to care for those clients that remained. One home care agency director explained: "We had to cut down 'cause we have a few caregivers that do multiple clients, so we had to cut them down to maybe one or two clients and that would help with the cross contamination. . . As far as the ones who're at home, all of them still wanted us to come in" (P63).

An essential element of maintaining engagement and avoiding loneliness for older adults in home and community-based programs throughout the pandemic was effective communication. As we discussed in chapter 3, and revisit in more detail in chapter 6, most community-based program staff assessed client needs through phone calls. Acknowledging the need for engagement and a sense of community, many program directors and caregivers turned to virtual programming in an effort to provide these critical components to their clients.

The greatest communication challenges were with the clients who were primarily sequestered in their homes, often isolated from family and friends. After one senior center closed, the staff began contacting program participants to find out about their technological resources and need for meal delivery services. One program director contacted the clients' children if necessary, who facilitated their parents' use of Zoom so they could communicate with their friends and families as well as begin participating in newly offered online programming. They explained:

> After a few weeks, it became apparent that we weren't gonna open again anytime soon. So we went back and started polling the seniors . . . and so we pushed and pushed and some of them said they didn't wanna do it [virtual programming]. But then once we felt like we had a really great core group . . . we set up a Zoom test and we had a full screen, and it was so cool because everybody hadn't seen each other. (P52)

These findings demonstrate both the need and ability to exert great flexibility in understanding and meeting the needs of clients in their homes. Shifting quickly to virtual programming, asking about emerging needs related to increased isolation, and engaging with new technologies and communication strategies were essential to meeting the needs of older adults now isolated in their homes. It is important to document the successes and chal-

lenges that occurred in the evolving landscape as the pandemic continued and as we consider the threat of future pandemics.

## Navigating Uncharted Waters

Preventing the deleterious effects of social isolation during a global pandemic proved a daunting task, especially in the early days of the pandemic when little was known about the virus. Those tasked with ensuring the mental and physical well-being of older Americans were unsure of how to alter the everyday engagement and activities for their clients and residents.

### *Staff Challenges Responding to Evolving Policies in Residential Long-Term Care*

The shifting landscape of infection control and policies made adapting particularly challenging in large part due to the unanticipated length of the pandemic. As one activities coordinator from a corporate-owned assisted living community stated:

> I've been limited on what I can do. At first, they told me, "Well, you can't have more than eight people." And so, during my exercise class, I'd have to cut it to eight people. That's hard to do. And then it was like, "You gotta have less than that," and that's hard to do, and then it's like, "You can't have any group settings." So, I was like, "What do I do? Do I even have a job?" (P41)

They talked about how the rules kept changing daily early in the pandemic until the lockdown when they had to provide engagement for residents who were isolated in their own rooms. We talked with them in August 2020, and they explained how they had adapted:

> I put everything I can on an activity cart, and I'll go from room to room and do different things with residents. First, I start off with the higher functioning residents because for them it's a quick visit. It's like, "I'll give you some puzzles, some crosswords, a daily bingo sheet, coloring, and all that stuff. I'll give you those things and you can work on them independently at your own time." So I kinda have to hit those folks first. And then, I go back to the people who are room-bound, aren't getting phone calls, aren't leaving their rooms, aren't happy, aren't walking, can't see. I have to go back and spend that time with them. (P41)

Activities coordinators became responsible for expanded, complicated, and time-consuming documentation in addition to their quickly evolving

job of individualizing activities in a changing infection-control landscape. One activities coordinator described the changes they experienced as an activities professional in assisted living:

> I'm sorry, whatever your job, your duties that you do have changed. In my department, activities. . . I don't concentrate on just parties and stuff now. Things have changed for me. For instance, even when I'm going in rooms, I've gotta wipe down everything. I need to keep up with family members who are visiting or who are FaceTiming now. My documentation is probably changing now. . . (P41)

This activities coordinator went on to explain how documentation was historically fairly routinized and repetitive but now it had to provide more details about individual engagement as activities were somewhat specialized based on the needs of the residents. As policy and program changes occurred rapidly, they were broadly experienced by staff members.

## Use and Availability of Technology to Foster Communication and Address Social Isolation

Related to the issues of social isolation discussed in this chapter, data collected in the early stages of this work revealed that the use of technology to address social isolation was an issue for most residential long-term care communities as well as home and community-based programs. The use of tablets, smartphones, baby monitors, and headphones to aid in connecting families with their loved ones proved invaluable although often insufficient. One staff member explained:

> I was worried about them not wanting to be alive anymore, I really was worried about some of the residents just being in a pit of sadness and starting to see their families more, and . . . doing the distance visitation helps so much to see them and have them come inside or just sit across at the conference room with them and visit. . . It was amazing. And they would cry and cry afterwards and saying how that just felt like years to them, they haven't seen their family. (P31)

Some long-term care communities were well equipped to make this adjustment and used available resources to stream programming to residents in their own rooms through their in-house systems. However, the majority of long-term care communities did not have this type of access. Our findings revealed that it was not uncommon for workers to use their own cell phones to facilitate video calls between residents and their loved ones. As

one participant stated: "family call staff members' cells or they call and bring the phone to the resident."

For persons living with dementia, the use of technology was less useful even though they were most vulnerable to the effects of isolation. Interfacing with technology whereby loved ones attempted to communicate with them was often disorienting. In chapter 5, we discuss the particular issues and challenges faced in using technology and fostering effective communication for persons living with dementia.

Staff in community-based programs turned to making telephone contact with their participants who were now stuck at home. They were able to identify clients who were isolated and those in need of support and assistance, and worked with other programs to be sure these needs were addressed. Technology was important in avoiding loneliness in both residential and community-based long-term care during the lockdown, but involved significant challenges.

## Discussion

Only with time and ongoing analysis will we fully understand the ramifications and lasting effects caused by the social isolation induced by COVID-19. Our findings demonstrate that isolation caused significant physical decline in the form of weight loss, and gait and balance issues as well as mental decline observed as lack of focus, social withdrawal, and irritability, which are classifiable symptoms of depression and anxiety. While some reversal of symptoms, notably weight gain, was identified once services resumed, a more robust study and follow-up are needed to determine the extent and duration of these effects.

COVID did shine a light on the issues of social isolation and loneliness particularly for older adults in need of long-term care, and the enormous challenges that staff faced in providing safe and effective care. Issues related to engagement and avoiding isolation and loneliness suggest the need to provide adequate staff resources and keep our in-person programs and services strong, along with increased use of technology and telehealth, as we move into the future.

Staff in all models of long-term care showed the value of a flexible human infrastructure. Participants, especially activities staff, demonstrated resilience, creativity, and an unwavering dedication to providing engagement for those in their care. This led to innovative programming as well as lifesaving interventions. Staff roles were expanded and in some cases, staff were reassigned with many staff willingly taking on new and more challenging responsibilities. Activities staff discussed their efforts to exchange

ideas and share best practices with others in similar positions. One interviewee explained how they sought ideas from other activities staff as well as the National Association of Activity Professionals.

> I do try to reach out to other activity directors to see what they're doing in their facilities, and of course, online, YouTube, to see all the videos that other facilities are doing, and we've been doing a bunch of COVID videos too, if you have a chance to check our videos out. We did a video. We did posters that said, "We're all healthy here." And we played music, and we did a parade. And so we've done videos on YouTube. But yeah, I just check out other facilities to see what they're doing. I'm always wanting to know what other folks are doing, 'cause I'm in this building all the time. (P41)

The essay at the beginning of this chapter highlights the efforts of activities staff in one residential long-term care community outside North Carolina to provide effective engagement under evolving restrictions, and the work of the National Association of Activities Professionals. In shortsighted responses by some long-term care communities, some activities personnel lost their jobs because they could no longer create engagement activities in the ways they had in the past. Those older Americans who they served undoubtedly suffered as a result. Instead, as our findings demonstrate, it is imperative to support these providers and honor their essential roles with more support and resources, not less, and encourage all long-term care providers to focus on engagement with the people they care for.