At the beginning families could not visit at all and virtual contacts were maintained in patients that could communicate. After the first wave a "drive in" method was carried out, families communicated with their relatives from a car.

During the second wave of the virus in Israel (September 2020), an outbreak spread in our residence. 14 patients tested positive for COVID19, all suffering from dementia or schizophrenia. They were immediately placed in quarantine in Corona departments in other geriatric and general hospitals. All patients came back after recovering, small part of them regressed.

As the pandemic continued we allowed visits with social distance and masks that were monitored by the staff. After vaccinations we allowed families to be with the elderly patients in the open yard without staff inspection. Four patients were infected during the third wave, although they were immunized. We had to consider every step of the way protection versus some autonomy to our patients and families and weigh creative ways to do this.

207 - The impact of changes in activities offered on care professional burden during the COVID-19 visitor ban in long-term care facilities

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Background

Residents of long term care facilities (LTCFs) and their professional caregivers have been hit hard by the coronavirus. During the COVID-19 outbreak, many countries imposed national visitor-bans for LTCFs. In the Netherlands, the ban was in place from 20 March 2020 onwards and ended (partly) on 15 June 2020. The usual meaningful and pleasant day structure that is created through organized (group) activities, was heavily impacted by the visitor ban. It remains unclear which particular types of activities were stopped, whether 'alternative' activities were introduced that may acquire a structural character in the future, and how this affected care workers.

Methods

We conducted online questionnaire research among LTCF residents, family members and care professionals at two time points; six weeks after the visitor-ban was implemented (T1) and one week after the ban was (partly) lifted (T2). The three groups received questionnaires on the consequences of the COVID-19 outbreak and the restrictive measures in place. Respondents were recruited independently for each measurement. This study only uses care professionals' data. The influence of the up- and downscaling of activities on care professionals' burden and ability to provide care was investigated using multivariate multiple linear regression.

Results

811 professionals completed the questionnaire during T1 and 324 care workers during T2. A decrease in regular group activities during the visitor-ban was reported. Especially exercise activities, creative activities and music activities were undertaken less frequently. Also domestic activities, such as eating together and watching television, took place less frequently as compared to before the visitor-ban. Activities that could be easily done on the unit, with sufficient social distance, were undertaken more frequently, such as music activities, conversations and playing games in the living room. The impact of the up- and downscaling of activities on care professional burden, and the perceived ability to provide adequate care, will be presented.

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Conclusions
Activities are an important means for residents of long term care facilities for obtaining pleasure and giving a meaningful structure to the day. Future lessons can be learned from the adjustments that had to be made in the range of activities offered during the visitor-ban.

208 - Person-centred infection prevention and control during a pandemic: The Dementia Isolation Toolkit

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Objectives: People working in long-term care homes (LTCH) face ethical dilemmas about how to minimize the risk of spread of COVID-19, while also minimizing psychological hardship and other harms of infection control measures on residents. The Dementia Isolation Toolkit (www.dementiaisolationtoolkit.com; DIT) was developed to address the gap in ethical guidance for LTCH on how to safely and effectively isolate people with dementia while supporting the personhood and well-being of residents. In this presentation, we will present the DIT and report on the results of a survey of LTCH staff in Ontario, Canada on their experiences isolating residents in LTCH and the use of the DIT in supporting person-centred isolation care.

Methods: A link to an online survey was distributed to LTCH staff through provincial organizations and agencies as well as through social media and the DIT website. Inclusion criteria were LTCH staff working on-site at a LTCH since March 1, 2020, who had direct or indirect experience with the isolation/quarantine of LTCH residents. Results were summarized descriptively.

Results: A broad sample of LTCH staff (n=207) participated in the survey, most of whom had experienced an outbreak in their LTCH. Dementia (96%) was the most important barrier to implementation of infection control measures in LTCH, followed by staff distress about the effects of isolation on residents (61%). Important facilitators for isolation included delivery of 1:1 activities in the resident's room (81%) and designating essential caregivers to provide support (67%), while inadequate staffing levels were reported as a barrier (55%). 65% of respondents indicated some familiarity with the DIT, and of those who had used the toolkit, 62% found it helpful in supporting isolation care, particularly in developing care plans and making and communicating decisions. Of those who had used the DIT, 48% found it fairly or very helpful at reducing their level of distress.

Conclusions: Isolation as an infection control and prevention (ICP) measure in LTCH environments can be harmful to residents and create moral distress in staff. ICP guidance and support of LTCH needs to address how to minimize these harms by providing dementia-specific guidance such as in the DIT.

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