CGNA Canadian Gerontological Nursing Association

PERSPECTIVES

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LIVING IN A PANDEMIC WORLD

On March 11, 2020, the World Health Organization declared that COVID-19 was a pandemic (World Health Organization, 2020). Since that date, the world has seen the emergence of COVID-19 variants, most recently the Delta and the Omicron. It is not clear if and when the next variant will appear and how much further chaos these variants may bring. Canada and many other countries have experienced repeated lockdowns to slow the curb of transmission of each new variant. Vaccines have been administered globally as well as booster vaccines, with selected immunocompromised individuals now receiving a 4th booster shot. There are hints that a booster vaccine may become an annual reality.

Two years into the pandemic we continue to see the devastating results of the pandemic on our healthcare system and in long-term care. We hear about the shortages of staff in all healthcare sectors. The shortages are related to illness or Covid-19 exposure and the need for quarantine and in other cases, nurses retiring or deciding to leave their jobs for personal reasons. The consequences of this pandemic seem never ending, with fatigued healthcare workers, worried family caregivers and the intermittent closure of public and private services.

Early in the pandemic we saw the shocking impacts of the pandemic on long-term care settings across Canada. Long-term care homes in some provinces are still struggling with finding enough nurses and health care workers to care with persons living in long-term care.

The pandemic impacts are distressing, yet as gerontological nurses we continue to ensure that the well-being of older adults remains a priority. Across Canada many pandemic restrictions are slowly beginning to be removed; looking forward I wonder what the post-pandemic world will look like, at this time next year or the following year.

Dawn Prentice
Editor-in-Chief, *Perspectives*

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- Promoting the scholarship of gerontological nursing in Canada and internationally;
- sharing the practice innovations of gerontological nurses;
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Dawn Prentice
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A STUDY EXPLORING THE IMPACT OF COVID-19 ON THE MENTAL AND PHYSICAL HEALTH OF OLDER ADULTS IN A SMALL RURAL COMMUNITY: WHAT WE LEARNED

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ABSTRACT

The objective of this study was to explore the impact of COVID-19 on the health of older adults and elicit ways communities and healthcare providers could support them. The group of older adults studied provided insight into what older adults want and need during and beyond this current crisis. Surveys consisting of open and closed-ended questions were completed by phone, online, or on paper (n=78) by individuals aged 65 years and older residing in rural Castlegar, British Columbia. A Likert scale was used to determine participant's retrospective and current levels of social isolation or loneliness and thematic analysis was performed to deduce the most prevalent themes. Our findings are consistent with other studies that have identified older adults as being an at-risk group for isolation-related negative health outcomes. Sixty-five percent of respondents felt moderate to severe loneliness after the implementation of physical distancing precautions, with 79% expressing an impact on their mental health. Themes included decreased overall mental wellness, anxiety, fear, grief, and loss. Additionally, 69% felt their physical health had been negatively impacted to some degree. Older adults in this survey reported that they experienced an impact on their health as a result of the pandemic. Their voices and stories of resilience provide a blueprint for community engagement initiatives during times of crisis and beyond.

Keywords: older adults, COVID-19, loneliness, isolation, grief, mental health, physical health

The Impact of COVID-19 on Older Adult's Mental and Physical Health

People aged 65 years and older account for 18% of the Canadian population (Statistics Canada, 2020) and although the COVID-19 pandemic is impacting many Canadians, the social isolation resulting from physical distancing has potentially devastating health outcomes on this vulnerable group (Fakoya et al., 2020). Social isolation is commonly defined as a low quantity and quality of contact with others (Keefe et al., 2006). "A situation of social isolation involves few social contacts and few social roles, as well an absence of mutually rewarding relationships" (Keefe et al., 2006, p. 1).

For many older adults, especially persons of lower socioeconomic status, physical distancing can equate to social isolation due to the lack of resources required to make social connections using technology (National Seniors Council of Canada [NSC], 2017). Additionally, the NSC (2017) proposes that older adults living in rural areas are even more vulnerable to social isolation due to lack of transportation, resources, and community supports (Duggleby et al., 2011; Keefe et al., 2006).

The importance of older adults following physical distancing precautions cannot be overstated and has been shown to slow the spread of the virus (Government of Canada, 2020). However, as we have seen in this pandemic, physical distancing can easily become social isolation for many older adults. Older adults are vulnerable to social isolation and experiencing loneliness because they are more likely to have risk factors such as death of loved ones, chronic health issues, sensory impairments, and changes in income (National Academies of Sciences, Engineering, & Medicine, 2020). Though not all people feel lonely when socially isolated, there is an increased risk for loneliness when social connections are being altered in one's day to day life.

There is ample room to better support older adults during times when physical distancing guidelines are being recommended. By learning from this demographics' experiences with physical distancing, nurses can improve the care and supports they provide and moving forward mitigate

the risks that physical distancing imposes on the health of older adults.

The Canadian Centre for Addiction and Mental Health (CAMH, 2020) found that since the onset of the pandemic, older adults are reporting symptoms of anxiety, depression, and loneliness in greater numbers. The World Health Organization (2020) has warned that older adults, especially persons living with underlying mental health issues, may become more anxious, stressed, and withdrawn during times of crisis. Fear of viral transmission is also likely enhanced in older adults who have a proportionally higher mortality rate associated with the infection (Verity et al., 2020). Additionally, limitations on recreation and routine social activities have added to the physical health risks. Staying home, as recommended by public health guidelines, can lead to inactivity and rapid declines in the health of older adults (Gill, 2014).

Grieving the loss of freedom, independence, social connection, or routines, may also be enhanced in older adults who have already experienced some degree of maturational loss and change (Brassen et al., 2012). What may be a seemingly minor loss for others, may be harder for older adults to cope with as it can reignite memories and emotions of a previous experience of loss (Healthlink BC, 2020). As people age, there is typically a progressive transition away from "doing" toward ways of "being" referred to as “gero-transcendence” (Rajani & Jawaid, 2015). “Being” refers to engaging in meaningful activities that sustain a person’s sense of self and purpose, as opposed to “doing” which is having a strong focus on working hard in the present for eventual long-term gain (Rajani & Jawaid, 2015). “Being” includes being present with others, reminiscing and remembering (Bohlmeijer et al., 2007). Sharing one’s wisdom and engaging in regular meaningful interactions promotes one’s mental and physical resilience (Färber & Rosendahl, 2020).

Resiliency is defined as the ability to successfully cope with the stressors of life and is linked to positive health outcomes in older adults (Färber & Rosendahl, 2020). Many older adults are highly generative (as described in Erikson's seventh stage of Psychosocial Development) and tend to confront difficult situations rather than shy away from them, furthering their sense of resilience (Perry et al., 2015). Both of these theories form the basis of understanding the importance of engaging older adults in solution-making to mitigate any potential negative impact this, or future crises, may pose.

Social Isolation and Older Adults

Approximately 30% of Canadian older adults are at risk of social isolation (Keefe et al., 2006), and the repercussions are a serious public health concern (Gilmour & Ramage-Morin, 2020). Social isolation is associated with an increased risk for dementia, depression, falls and a decreased sense of wellbeing (Gilmour & Ramage-Morin, 2020). Social isolation is also a significant risk factor for loneliness, which contributes to a higher risk for hypertension, heart disease, obesity, anxiety as well as depression (National Institute on Aging, 2019). Together social isolation and loneliness contribute to poor physical and mental health outcomes in older adults. Surveys completed by CAMH (2020) over the summer of 2020 indicated that 18% of respondents aged 60 and over were experiencing loneliness as a result of social isolation imposed by the pandemic. Older adults in Italy (De Leo & Trabucchi, 2020) and China (Wang et al., 2020) were expressing similar experiences, indicating that this is a far-reaching phenomenon.

The loss of social connection is troubling as research demonstrates its protective effects on mortality among older adults (Holt-Lunstad et al., 2010). While younger generations may easily move to use technology to access supports and make a social connection, older adults may not be able to adapt as quickly or in a similar fashion. Though Canada has adopted virtual delivery for many health services, these may not be adequate to meet the need for connection, nor be accessible to persons on fixed budgets (Flint et al., 2020).

Though there is awareness of the impact of social isolation and loneliness in older adults, there are few studies exploring older adults' perspectives on how to solve the issue during the pandemic and beyond. Although it is hard to predict the impact of this sustained pandemic on older adults mental and physical health, there is awareness that such traumatic events, can have prolonged long-term effects (Ogle et al., 2014). This study aims to fill this gap and let the voices of Canadian older adults be heard to develop initiatives to minimize the on-going risks.

Impact on Mental Health

Age alone increases one’s vulnerability to all forms of stress (Lavretsky & Newhouse, 2012). Adding social isolation and fear related to the threat of the unknown has the potential to magnify the impacts on mental health. Older adults make up the majority of COVID-19 related deaths worldwide (Verity et al., 2020), and this has routinely been conveyed in the media. Being acutely aware of this vulnerability has undoubtedly added to the stress of many, especially older adults with cumulative risk factors (Verity et al., 2020). Although older adults are advised to follow the same guidelines as the general population, physical distancing, in addition to the fear associated with personal risk, is a confounding worry for many. For example, Wang et al. (2020) reported that 53% of their survey respondents rated the psychological impact of the pandemic as moderate to severe and Callow et al. (2020) found that older adults

with previous mental health issues, including anxiety and depression, were at an increased risk for declining mental health during the pandemic. These studies support our position that there is a need to identify older adults most at risk and implement measures that promote resilience.

Furthermore, CAMH (2020) found that 16.4% of the older adults surveyed reported moderate to severe anxiety, and 13.1% reported feeling depressed during the pandemic. Though these numbers are higher in other age groups of Canadians, it may simply be because CAMH used an online reporting platform which may have limited the number of older adult respondents. Callow et al. (2020) surveyed adults age 50+ living in Canada and the United States and found that 63% of survey respondents were experiencing moderate depression and 11.3%, severe depression. They also found that 64% experienced mild anxiety and 6.9%, moderate anxiety (Callow et al., 2020). These numbers are concerning because loneliness and decreased social support are associated with an increased risk of dementia (Dröes et al., 2017), depression (Okura et al., 2017), and cognitive decline (Callow et al., 2020). Although there is evidence that older adults have lower rates of anxiety, depression, and post-traumatic stress than younger age groups (Vahia et al., 2020), the long-term impacts of social isolation on the prevalence of these conditions may take months or years to determine – highlighting the urgency for early prevention and health promotion initiatives.

Impact on Physical Health

Callow et al. (2020) found that 37.6% of North American older adults reported doing 'much less' or 'somewhat less' physical activity since the start of the pandemic. Yamada et al. (2020) found Japanese older adults reported an average decline in physical activity by 65 minutes/week. This trend could lead to increased frailty and its known adverse health outcomes such as increased falls and disability (Ensrud et al., 2009).

Closure of recreational facilities impacts many older adults' ability to maintain their physical health in ways they are accustomed to, especially during the winter months when indoor activities are most popular. Limited access to recreational resources due to transportation issues, closures, and physical distancing precautions contributes to older adults being less active. Lack of physical activity, social isolation, and changes in diet and mood (Payne, 2010), are all positively correlated with prevalence of cardiovascular disease (Shankar et al., 2011).

In their Canadian study, Davidson and Schimmele (2019) found that internet usage declines with age due to factors such as lack of knowledge, interest and /or access to technology indicating older adults may be less likely to utilize online exercise options than younger adults.

Additionally, the adoption of less healthy ways of eating, such as purchasing more processed foods in an effort to limit the number of times grocery shopping is required, can further contribute to poor health (Government of Canada, n.d.). Lastly, decreased access to face-to-face medical appointments and delays in medical procedures, have the potential to directly and indirectly contribute to declining physical health.

Study Purpose

Though there is an abundance of data on the impact of COVID-19 on persons living in long-term care, less attention has been given to the impact of COVID-19 on the mental and physical health of community dwelling older adults. This large demographic is at significant risk for social isolation and decline in their mental and physical health that may be less visible in many communities. This study explored the impact of COVID-19 on the health of older adults and elicited ways communities and healthcare providers can support older adults moving forward.

METHODS

Design

This study utilized a survey method consisting of open and closed-ended questions aimed at understanding the experiences and perspectives of older adults (Appendix A). The survey was developed by the authors based on clinical experience and a literature review. The survey was then reviewed by a panel of experts, including social workers and nurses who work with older adults and revised according to recommendations. Some questions were eliminated due to redundancy and others were revised for clarity. The survey was pilot tested with older adults and then revised for clarity based on the feedback obtained.

Sample and Setting

From May 1, 2020 to September 10, 2020 an online, telephone, or paper survey was completed by 78 community-dwelling older adults living in and around Castlegar, B.C. Participation criteria included being cognitively intact, aged 65 and older and living in and around the Castlegar area. Recruitment of respondents was through newsletters to a local older adult's group, radio broadcasts, and newspaper advertisements. All procedures performed in this study were approved by and in accordance with the ethical standards of the Selkirk College Research and Ethics Committee.

All respondents gave informed consent and were aware that their responses were anonymous and confidential.

Data Collection

Respondents completed the survey using the method preferred. Data on age, gender, and whether the participant lived within or outside city limits were gathered. Respondents were asked to retrospectively rate their level of loneliness and isolation before the pandemic and presently. A 10-point Likert scale (0 being the least lonely/isolated and 10 being the most lonely/isolated) was used. The remainder of the survey was composed of open-ended questions (Appendix A).

Data Analysis

Quantitative data from the closed-ended questions was analyzed using descriptive statistics in Excel. The qualitative data from the open-ended questions underwent thematic analysis whereby all members of the research team read the results independently then met as a group and by consensus agreed upon the main themes.

RESULTS

Demographics of Respondents

Our response rate was 3.9% based on the 1,985 older adults living in Castlegar (Statistics Canada, 2016). Of the 78 respondents, 17% lived outside of city limits, while the rest lived within city limits. Sixty percent of respondents were aged 65-74 years, 37% aged 75-84 years, and 2% were aged 85-94 years. Eighty percent identified as female and 20% as male.

Themes

Social Isolation and Loneliness

Fifteen percent of respondents reported feeling moderate to severe loneliness or isolation before the pandemic. This increased to 65% after the implementation of physical distancing. When asked how the physical distancing precautions had impacted their lives, an overwhelming number of respondents brought up feelings of isolation and loneliness. Over half of the respondents stated that the source of their loneliness was due to the inability to see friends and family or maintain a social connection through routine activities. Sixty-eight percent of the respondents identified loss of autonomy and freedom due to the physical distancing restrictions, with 40% describing a loss of some form of social connection.

When asked how the current situation with COVID-19 had impacted their mental health, 33% of the respondents alluded to increased loneliness and expressed a loss of social connections due to the closure of facilities where social connections were made. When asked what sort of communication strategies they predominantly used to stay connected, 84% used the telephone, 67% used Zoom or FaceTime, and 48% used text messages. Although older adults may be using technology to connect, the simultaneous increase in a sense of loneliness indicates that technological connection alone was not successfully replacing all situations where meaningful connections were made.

When asked what supports and services older adults felt they needed during the pandemic, 40% mentioned needing support with making social connections while following public health guidelines, such as connecting at recreational facilities, restaurants, and community centres. Surprisingly, 24% indicated a need for more clear, current information regarding COVID-19 and supports to help them cope. Of the responses related to COVID-19 public health guidelines, 45% of respondents spoke about how they would like to see masks made mandatory and enhanced enforcement of physical distancing, indicating that many older adults are supportive of public safety measures.

Respondents were also asked if they worried about any other older adults in their community and what services might help support people. Fifty-seven percent of the respondents suggested providing more emotional/mental health support for individuals (e.g., routine telephone or in-person check-ins). The remainder of the responses (43%) included supporting older adults' physical health by providing services such as laundry, cleaning, and healthy meals. Other suggestions made by older adults included walking groups, recreational opportunities, gatherings that abide by physical distancing regulations, education on coping strategies, and information regarding services that are available to help older adults.

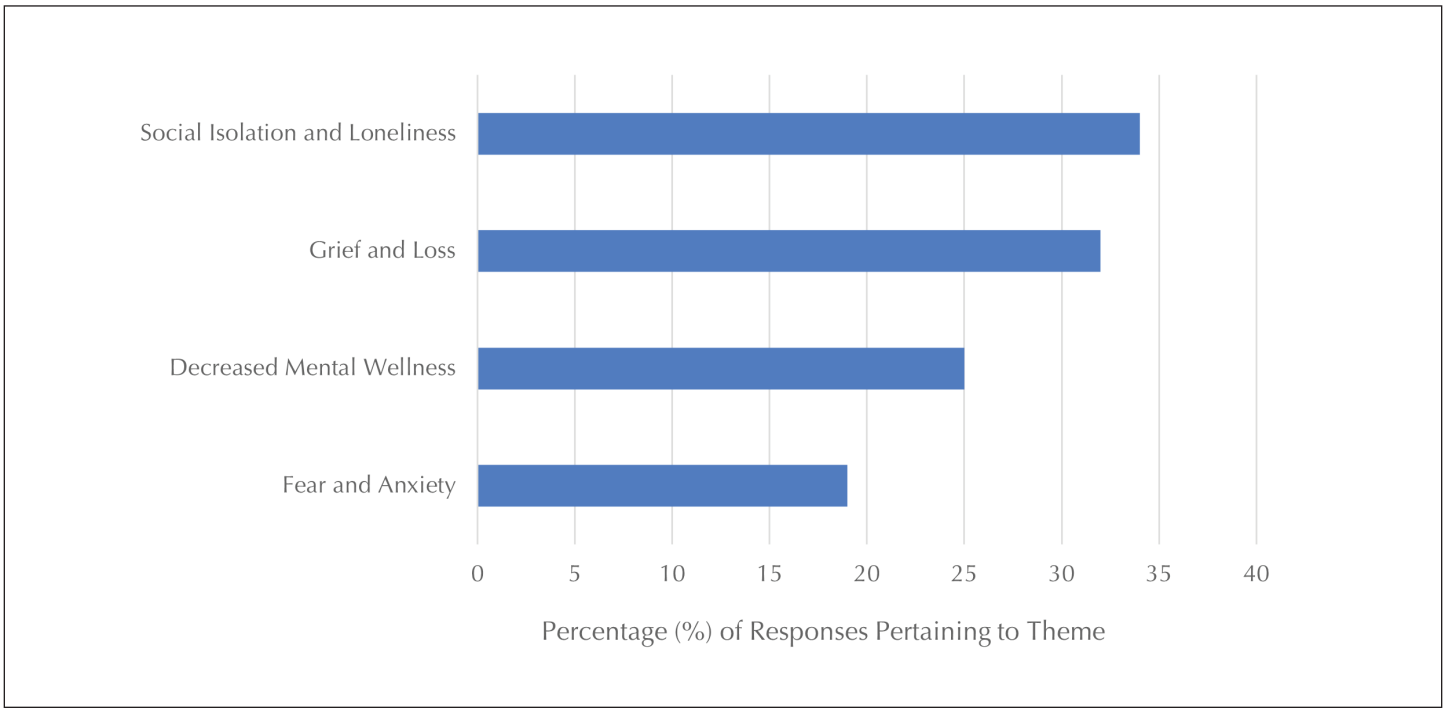
Mental Health

When asked about the impact COVID-19 has had on the older adult's mental health, 79% felt it had negatively impacted them in some way. The major themes included increased loneliness, anxiety/fear, and feelings of loss and grief (see Figure 1).

Twenty-five percent of respondents described feelings of depression, sadness, or unhappiness. Tearfulness, increased levels of stress, insomnia, and weight gain were also described by respondents as harming their mental health.

Nineteen percent of the responses related to increased fear and anxiety. Of these, 70% described fear surrounding the transmission and/or contraction of the virus. Concerns regarding a lack of current, clear information on public health guidelines as well as personal safety were raised as factors influencing anxiety and fear. The remaining responses all described fear and anxiety related to the safety of loved ones. Some respondents mentioned their anxiety required medical intervention. For example, one older adult stated,

Figure 1
Prevalence of Each Theme in Responses Related to the Impact of COVID-19 on Mental Health



> *"Mentally it added a lot of anxiety, especially at the beginning. I wasn't able to sleep well and it affected my health, so my doctor has recommended I take anti-anxiety medication before I go to sleep so that has helped me a lot."*

Grief and Loss

Another prominent theme captured in 31% of the responses, was grief and loss related to COVID-19. Grief was associated with personal losses including loss of routines, rituals, autonomy, employment, social connections, loved ones, and relationships, which was also reflected in the CAMH study (2020). Though all generations are likely feeling some level of grief our results indicate that older adults may be experiencing it more profoundly. One respondent stated, "Dispirited - Little to distract from the constant barrage of gloomy news with little hope that there will be a return to the "norm" (concerts, theatre, sports) in my lifetime." This comment illustrates the sentiment many older adults expressed in our survey; the pandemic is limiting their autonomy and quality of life.

It is unclear from our survey what the underlying contributing factors are to older adults' experience of grief or if there are specific variables that are unique to this population as opposed to other groups (e.g., perception of one's projected life-expectancy, missing milestones of grandchildren). Pandemic-related grief was a prevalent theme throughout our survey and came up in questions regarding mental and physical health.

Physical Health

When asked how COVID-19 has impacted their physical wellness, 69% of the respondents stated they were negatively impacted. Deconditioning, exacerbated health issues, weight gain and decreased activity due to fewer opportunities to safely recreate were among the most common themes. The remaining respondents stated no change in their physical wellness or that they had increased activity levels due to having to do more tasks independently around the house.

For respondents who felt their physical health had been negatively impacted, 54% felt this was related to the closure of recreational facilities and programs in the area with 22% reporting weight gain. Nineteen percent reported that previous health issues had been exacerbated by inactivity during the pandemic leading to ailments such as stiff joints, weakness, increased chronic pain, and increased blood pressure, supporting the idea that pre-existing health issues are being further complicated by the pandemic in some individuals.

Thirty-four percent of respondents stated that changes in the delivery of healthcare services had negatively impacted their physical health. They mentioned how healthcare

services such as primary care, physiotherapy, massage therapy, and chiropractic care were either stopped or moved to remote delivery (telephone or virtual meeting), and how these services played a critical role in maintaining their general health and functional capacity.

Similarly, some respondents spoke about how a move away from face-to-face access contributed to a decreased overall quality of connection with these critical support people. For example, one older adult stated, "It's stressful to not see my physician in person. Phone visits just aren't the same, even if safer." Generally, respondents felt that the telephone appointments were not as helpful and indicated that delays and cancellations of appointments, surgeries, and referrals had contributed to a decline in both their physical and mental well-being in some way (e.g., prolonged pain, worsening conditions, uncertain health status, and progressive loss of function). Regarding nutrition, many older adults appreciated the safety of food delivery services, however, they spoke about the loss of routine, purpose, and social connections that regular outings to buy groceries provided.

DISCUSSION

Overall, the results of our study indicated that older adults were experiencing some degree of negative impact from the current COVID-19 crisis on their mental and physical health. Though much research and media allude to this, few studies have asked older adults their opinions on how their transcendence, generativity and resilience can be fostered over the long haul. This is where our study has offered new findings and furthered understanding of the experiences of some older adults.

Respondents participated in the study between May to September of 2020 and were asked to first retrospectively rate their level of loneliness prior to the pandemic and then again at the time of the survey. Our pre-COVID findings are similar to those published by Gilmour and Ramage-Morin (2020) who found that 12% of community-dwelling Canadian adults aged 65 and older reported feelings of loneliness and social isolation. Similarly, Kobayashi et al. (2009) found that 17% of persons aged 65 and over, living in small towns or rural areas of BC felt socially isolated.

These results form the basis of our belief that this group would be exponentially impacted by necessary restrictions on social connection. When asked to rate their current level of loneliness, during the pandemic, 65% of respondents stated they felt moderate to severe loneliness or isolation. This result was vastly higher than those from a survey conducted by CAMH (2020) which found that 18% of people aged 60 and over have felt lonely during the pandemic. The difference in our results could be due to utilizing different methods to measure loneliness and social isolation, the age composition of our samples, or perhaps the geographical location and socioeconomic status of respondents. Additionally, we did not gather data on ethnicity nor Indigenous status, and this, in retrospect, would have contributed to a more holistic understanding of our demographic.

One strength of our study was that we asked the same respondents their self-rated loneliness and social isolation both before and after the onset of the pandemic, exposing that there is indeed a trend towards increasing loneliness and feelings of social isolation due to COVID-19 precautions and risks. Older adults tend to make social connections outside of the home through volunteering, attending church, senior centres, and recreational groups (Armitage & Nellums, 2020). Our survey confirmed that a large majority of respondents were having a hard time making fulfilling social connections with others once many of their social outlets closed. This is troubling as research has shown that low participation in social activities puts older adults at a higher mortality risk (Gilmour & Ramage-Morin, 2020) and bodes the question of how these connections can be fostered in the current climate. For example, many respondents spoke about how even weekly grocery shopping was a social outing for them that they no longer did due to fear of contracting the virus.

As seen in the literature from China, Italy, and North America (Callow et al., 2020; De Leo & Trabucchi, 2020; Wang et al., 2020), the responses to our open-ended questions regarding mental health indicated the pandemic is causing increased feelings of anxiety, depression, and sadness. Our results show an 11.9% higher rate of depressed mood and a 2.6% higher incidence of anxiety compared to the CAMH's (2020) national survey. Though we measured psychological impacts using differing methodologies, our results agree with both Callow et al. (2020) and Yamada et al. (2020) that support the findings that COVID-19 is having a negative impact on many older adults.

Where our results add to the literature is in providing insight into why older adults are feeling more anxious, lonely, and depressed at this time. The most prevalent reasons include fear of transmission of the virus and unclear public health guidelines. Older adults stated they wanted more current, clear information regarding the public health guidelines and wanted these guidelines to be better enforced in the community. Our results indicated initiatives that help older adults access clear information on COVID-19 would help reduce the fear and anxiety and promote a sense of autonomy and pro-activity. Regarding depression and loneliness, loss of face-to-face social connection was the leading contributor. Creating opportunities for older adults to safely socialize in new and innovative ways would be crucial in addressing this

need. Organizing phone conversations between college students and older adults and physically distanced walking groups are just a couple of the initiatives that we have implemented locally to support the mental health of older adults in our rural community.

Overall, the most prevalent theme in our survey was pandemic-related grief. This theme came up in multiple questions and it was clear that many of the older adults surveyed were grieving a multitude of losses. For the most part, older adults articulated grieving the loss of social connection, relationships, autonomy, routine, and time. Although they understood and supported the need for precautions, they expressed grieving over diminished social freedom and independence particularly related to social engagement. Our results illustrate the need to recognize grief and find ways to help support older adults to healthfully cope with this sense of loss.

The voices of older adults are calling for health initiatives that focus on supporting them in maintaining their social connections while abiding by public health guidelines. Also, they are asking for ways to discuss the impact of the pandemic on their personal lives and share coping strategies that can help mitigate the risks the pandemic poses on the most vulnerable within this group.

Lastly, regarding the impact of the pandemic on the physical health of older adults, our results were congruent with the literature in that older adults reported decreased physical activity (Callow et al., 2020; Yamada et al., 2020). Again, where our findings add to the literature lies in the reasons behind this general decline in physical health. Older adults indicated that the closure of recreational facilities, senior centres, and a halt in group activities were having a profound impact on their physical wellness. Health initiatives that promote activity and ensure public health guidelines are being followed can help older adults maintain their physical health during the pandemic. Educating older adults on safe ways to participate in various recreational activities can help promote activity during the pandemic, as well as assist in establishing strategies that contribute to long-term health and vitality.

Gerontological Nursing Implications

Although this study explored how older adults believe their health has been impacted by COVID-19 and what supports they feel would be helpful now, what we discovered is foundational in designing public health measures to support the health of older adults well beyond this current crisis. Our data has highlighted some positive coping strategies that many older adults have developed over the course of the pandemic as well as areas where more supports are needed. We learned that older adults need and want to be a part of the development of the initiatives that support them.

We also learned that loneliness is very prevalent in this population and that a shift to a proactive approach, to early or pre-emptive intervention, is needed in order to minimize the potential impact that this pandemic and future crises may have on older adults.

For nurses who serve the gerontological population, our data highlights several key principles that can be applied in practice, whether that be one-on-one interactions, program planning or policy development. Nurses should routinely assess older client's level of isolation and loneliness and pre-emptively identify people at risk. Nurses should also routinely engage older adults in conversation about how they are coping and what they are doing or need to feel their best. Creating trusting therapeutic relationships and actively exploring clients' sense of purpose, power and control are essential. The therapeutic relationship is the gateway to discovering who the client is, and what their needs are for health and wellness.

Nurses should work in partnership with their clients and interprofessional team members in the development of client-centred interventions, including reaching out to various community organizations to explore innovative and collaborative approaches that can be used to prevent and/or restore wellness.

Lastly nurses play a critical role in research and policy development and nurses working within the community are encouraged to partner with local schools of nursing to engage students in community-based scholarship and problem-solving initiatives. The desire to assist older adults in maintaining wellness and longevity must be matched with a willingness to initiate even the smallest of changes without fear of failure or lack of global support.

In summary, being aware of the implications and potential long-term effects of the pandemic gives nurses the advantage of acting intentionally and pre-emptively to minimize the impact crises such as the pandemic have on older adult's health and well-being.

Limitations

It is hard to determine from our study what variables, including the degree of personal resilience, stage of life, or acceptance of one's mortality, influenced the responses we obtained. Additional limitations include the small sample size and the rural setting. Because the survey was performed in a small town in B.C., findings may not be generalizable to urban settings where there may be more services accessible to older adults.

Another limitation of this study lies in the survey itself. In retrospect, it would have improved our ability to compare our results to previous literature had we gathered data on cultural background and utilized similar, validated scales

to measure variables such as social isolation and loneliness rather than using our Likert scales. Additionally, there may have been benefit in explicitly exploring the positive impacts this crisis is having on this population as this could assist researchers, policy makers, and program developers in recognizing the resilience traits that are providing a protective cushion that could be maximized.

Future Directions

When the themes of grief and loss surfaced in our results, we immediately recognized that this was an area that needed to be researched further. Understanding the perspectives of older adults and how public health initiatives can help with pandemic-associated grief can be impactful moving forward. This study was largely exploratory; aimed at finding out the needs of older adults during the first year of the pandemic.

Designing, implementing, and researching the outcomes of health initiatives that are guided by our survey results would be a natural next step. Also, comparative research utilizing similar methodology is needed to compare findings between urban and rural settings to ascertain whether location impacts risk for social isolation during times of crisis. As new variants emerge and the threat of further waves loom in Canada, we need to prepare to help older adults cope and maintain their health.

Though public health guidelines recommending that high-risk groups stay home are indeed protecting older adults from contracting COVID-19, the resulting collateral risk needs to be recognized and pre-emptively addressed. We urge leaders in public and community health to continue to innovate and implement services for older adults while abiding by public health guidelines to help support their mental and physical health. As a society, it is our moral and ethical duty to do more to improve the quality of life of older adults during these difficult times.

Lastly, it would be imperative that post-pandemic research be conducted on the long-term positive and negative impacts of the current pandemic on older adult's physical and mental health and subsequent morbidity and mortality rates. To assume that once the pandemic is over, the current issues will dissipate with no residual effect, would be misleading. Additionally, there may be numerous positive aspects of the pandemic that are unique to this population that can assist policy and decision-makers in creating ongoing strong supportive communities. Our results validate the importance of including older adults in determining the services they need to remain active, vital members of their communities.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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Appendix A

Survey Questions:

We would like to acknowledge that not everybody has the same beliefs about the validity of the restrictions so please consider the impact of the restrictions on you, not your individual beliefs about their validity.

1. Have you read the survey information and confirm that you are participating on a voluntary basis and understand that you have the right to withdraw your participation at any time?
2. On a scale of 0-10 (0 being the least and 10 being the most) how lonely or isolated did you feel ***before*** the implementation of COVID-19 Social Isolation restrictions?
3. On a scale of 0-10 (0 being the least and 10 being the most) how lonely or isolated did you feel ***after*** the implementation of COVID-19 Social Isolation restrictions?
4. The current COVID-19 pandemic has resulted in the implementation of certain restrictions. What, if any, challenges did you face / are you facing as a result of these restrictions (what needs are you finding hardest to have met and why is it hard for you?)
5. How has the current situation affected you physically?
6. How has the current situation affected you emotionally/mentally?
7. What activities of daily life have you found most challenging to maintain (e.g., banking, shopping, accessing healthcare recreation/exercise etc.)
8. What strategies are you using to help you cope?
9. What strategies or supports do you think would be most helpful to maintain your physical and mental wellbeing?
10. Which of the following have you been using to stay in touch with friends and family?
    - Telephone
    - FaceTime
    - Zoom
    - Other:
    - None
11. Considering your experience, would you be interested in interacting with Selkirk College students at IRIS?

THE IMPACT OF OLDER ADULTS' LIVING ENVIRONMENT ON THEIR HEALTHY AGING IN PLACE DURING THE COVID-19 PANDEMIC

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ABSTRACT

Older adults 65 years and above are among the population most affected by the novel coronavirus, which was declared a global pandemic in 2020. Nineteen older adults from Saskatchewan were interviewed from three living arrangements: private homes, cohousing, and assisted living through telephone call or videoconference to describe the impact of older adults' living environments on their healthy aging in place during the COVID-19 pandemic. The themes that emerged from the data were: safety in living arrangements, benefits of the pandemic, challenges from the pandemic, the need for support systems, and coping strategies. A major finding from the study was that all the older adults felt safe in all three living arrangements. The older adults, particularly those from private homes, reported feeling lonely, isolated, and a little depressed at the start of the lockdown. Many older adults coped with the isolation by connecting with family through technology, knowing their neighbours and neighbourhood, working in their garden, going for walks, watching TV, and reading. The findings from the study contribute to our understanding of the experiences of older adults during COVID-19 and confirm that facilitating social interactions is a key component of older adults' healthy aging in place. Feelings of loneliness among older adults, which was exacerbated by the COVID-19 pandemic, needs to be addressed in recovery from the pandemic to prevent complications resulting from social isolation.

Keywords: older adults, private home, cohousing, assisted living, healthy aging, COVID-19 pandemic

THE IMPACT OF OLDER ADULTS' LIVING ENVIRONMENT ON THEIR HEALTHY AGING IN PLACE DURING THE COVID-19 PANDEMIC

The World Health Organization (WHO) declared the novel Coronavirus [SARS-CoV-2], which causes COVID-19, a respiratory disease, a public health emergency on March 11, 2020 (Government of Canada, 2021; Nascimento, 2020). COVID-19 infection may lead to severe complications such as cardiac injury, respiratory failure, and death in older adults with one or more pre-existing comorbidities (Wang et al., 2020). A key intervention to prevent the transmission of COVID-19 is physical distancing, which can result in social isolation and social distancing. Social distancing measures during the pandemic present unique challenges, including anxiety, stress, and depression for an older adult who may already be experiencing loneliness or dependence on others to fulfill their daily needs (Alzheimer Society of Canada, 2020; Wang et al., 2020). These challenges have implications for older adults' healthy aging in place, that is, having the health, social supports, and services one needs to live safely and independently in one's home or community for as long as a person desires (Government of Canada, 2016). In the last year, Canadians have witnessed the severe impact of COVID-19 on older adults' wellbeing as home care and community supports were reduced, cancelled, or transferred online, and cross border travel was restricted (Alzheimer Society of Canada, 2020; Government of Canada, 2020; Meisner et al., 2020; Wang et al., 2020). However, little is known about how older adults' housing options support their health, social connection, mobility, and independence during the COVID-19 pandemic.

The purpose of this study was to describe the impact of older adults' living environment on their healthy aging in place during the COVID-19 pandemic. The objective guiding the paper was to provide a rich description of older adults' experiences in their living environment during the pandemic to increase society's understanding of their wellbeing. The research question was, "how does older adults' living environment promote their healthy aging in place during the COVID-19 pandemic?"

LITERATURE REVIEW

Multiple factors, including an individual's composition, physical environment, social interaction, independence, cognitive/mental health, mobility, transportation, services

such as recreational opportunities, healthcare and information work together to impact older adults' healthy aging (Bigonnesse, 2017; Puplampu, Matthews, et al., 2020). Healthy aging is a multidimensional construct that indicates the older adult is doing well; it can be defined as promoting and optimizing the health of an older adult by managing chronic diseases, ensuring cognitive, physical, and mental health, facilitating social engagement and resilience, independence, safety, support and services from the community (Batsis et al., 2021; Government of Canada, 2016; Lock & Belza, 2016; Pac et al., 2019).

Promoting healthy aging in place for older adults aligns with the United Nations and Government of Canada agendas and Saskatchewan's provincial action plan on aging; all of which aim to empower older persons to enter older adulthood in improved health and to provide supportive environments where people can age with security and dignity and are able to participate in the community (Saskatchewan Provincial Advisory Committee of Older Persons [SPACOP], 2003; United Nations, 2002). Housing for older adults plays a key role in their healthy aging, which became apparent during the COVID-19 pandemic as long-term care facilities in Canada became high-risk settings and sources of outbreaks and deaths (Public Health Agency of Canada, 2020). The need and urgency to research older adults' living environments and their impact on healthy aging was evident during the pandemic. While long-term care settings were the focus of research during the pandemic because of the increase in outbreak and death, it was also crucial to explore how older adults in other living arrangements were doing considering the global impact of the pandemic across all settings.

Housing Options for Older Adults in Saskatchewan

Older adults in Saskatchewan have a range of housing options to choose from such as personal care homes, retirement communities, assisted living, low-income housing programs, and nursing homes (called Special-Care Homes [SCH] in Saskatchewan) depending on the level of care they require (Garner et al., 2018; SPACOP, 2003). Assisted living accommodation situations are often very expensive and are mostly paid for out of pocket (Garner et al., 2018; SPACOP, 2003; P. Benson, personal communication, May 28, 2021). The costs of Special Care Homes (nursing homes) are heavily subsidized by the provincial government (Garner et al., 2018; SPACOP, 2003; P. Benson, personal communication, May 28, 2021). Assisted living arrangements and Special Care Homes, which are examples of traditional housing for older persons, have long wait lists (Garner et al., 2018; SPACOP, 2003). Older adults who choose to reside in their own homes rely heavily on social and practical support from family and friends (Garner et al., 2018; P. Benson, personal communication, May 28, 2021). Nearly 11.6% of Canadians aged 65 years and above live in private homes in the community and have care provided by informal caregivers (Garner et al., 2018).

In this paper, the researchers focused on three housing arrangements, cohousing, assisted living arrangements, and private homes, to explore their impact on older adults' healthy aging in place during the pandemic. Cohousing, a private living arrangement developed, owned, and managed by the occupants, has many advantages such as providing social interaction and mutual support to the residents (Puplampu, Matthews, et al., 2020). Similarly, retirement communities support older persons through services such as cleaning and laundry, assistance with activities of daily living, and others (Campbell, 2016). Older adults who live in their private homes have the benefits of staying in their homes at reduced cost and maintaining their autonomy. Although Canadians have witnessed the impact of the COVID-19 on older adults' wellbeing, particularly people who live in nursing homes, little is known about how the three housing arrangements focused on in this research have impacted older adults' healthy aging during the pandemic.

METHOD

The researchers employed a qualitative descriptive method guided by semi-structured questions to explore older adults' experiences in their living environment during the COVID-19 pandemic. The qualitative descriptive approach allowed the researchers to provide detailed summaries to describe participants' experiences and opinions on their healthy aging in their living arrangement during the pandemic (Barroso & Cameron, 2018; Puplampu, Peters, et al., 2020).

Setting

Three living arrangements, cohousing, assisted living arrangements, and private homes, were the settings for the study. The first living arrangement was a multi-generational cohousing community that was opened on October 18, 2019, in one of the cities in Saskatchewan; the building has 30 people – 16 of whom are older adults (L. Adams, personal communication, March 9, 2021). The building has three floors with 21 private units, an elevator to all floors, underground parking, and guest bedrooms with ensuite bathrooms. This building also contains shared common spaces such as a kitchen, a dining room (seating 40), a lounge, a large workshop, rooftop terraces on the 2nd and 3rd floors, a patio adjacent to the dining room, ten raised garden beds (approx. 2.5ft by 10ft), and a garden area (approx. 40ft. by 40ft).

The second living environment included two assisted living communities operated by the LutherCare Communities, which provides an independent retirement residence and intermediate care homes for older adults who cannot live alone but do not meet the criteria necessary to require

the services a special care home provides (LutherCare Communities, 2021). The suites are rented on a monthly payment plan. The first building in the LutherCare Communities was opened in 1978 and is 22-storeys high with 195 suites, 15 of which are assisted living suites; each suite has one bedroom and a kitchen. The second building was opened in 2017 and has 159 suites with each suite having a built-in kitchen and laundry. Twenty-seven of the 159 suites provide assisted living environments. Suites range in size from about 700 square feet to 1216 square feet.

The third living arrangement involved in the study were private homes, which covers bungalows, duplexes, and condos. Participants from private homes were recruited through the Saskatoon Council on Aging (SCOA). Some private home participants lived in a three-storey condominium, which was constructed in 1989 and is wheelchair accessible and has below ground parking. It is occupied by residents who are mostly 50+ years of age, including two people who participated in this study (P. Benson, personal communication, February 23, 2021). Some residents in this building have full time or part time employment. The facility is located within walking distance of grocery stores and many other amenities.

Recruitment

The researchers recruited older adults aged 65 years and above who were residents of Saskatchewan and able to communicate in the English language. Participants were recruited from one of the cohousing communities in the province, two LutherCare Communities in Saskatoon, and private homes in Saskatoon through SCOA after institutional ethics approval and community/agency permissions were received. The research team advertised the study's poster in the SCOA e-newsletter and electronically emailed the recruitment poster to the contact persons from the other two housing arrangements who were part of the advisory group on the project. The advisory group members verbally introduced the study to their community members and invited interested participants to contact the principal investigator (PI). The partner organization (SCOA) and the two housing arrangements shared with their board members the principal investigator's request for one representative from their organization/community to serve on the advisory group committee. Each organization administrator provided the name of the identified person to the PI who then contacted them and arranged virtual meetings for the three advisory group members to participate on the project.

Data Collection and Analysis

Data collection took two months, from August 2020 to September 2020, when saturation was achieved (that is, when no new information was obtained from participants) (Barroso & Cameron, 2018). We interviewed each participant either via telephone call or videoconference and each interview lasted between 30 and 60 minutes. The interviews were facilitated by an interview guide with questions such as "tell me about your experience with staying at home during the COVID-19 pandemic?" Probes, including "could you provide an example of the experience," were used to allow participants to share their opinions on their housing option and its impact on their ability to age in place healthily. Participants' demographic data such as age, gender, marital status, level of education, income, living arrangement, self-report of health status, use of professional services, such as meals on wheels and home care, and mobility, were collected at the start of each interview to assist researchers to identify factors that may impact their healthy aging during the pandemic (Puplampu, Matthews, et al., 2020). The first author conducted all interviews, which were audiotaped and transcribed using a professional transcription service.

The research team employed thematic analysis to identify patterns from the transcribed data to provide rich description of participants' experiences in their living environment during the pandemic and reported the findings (Braun & Clarke, 2006; Puplampu, Matthews, et al., 2020; Puplampu, Peters, et al., 2020). The data analysis commenced with open coding by writing words directly beside text in the transcript to describe the text (Nasstrom et al., 2016). The first author coded five transcripts to be immersed in the data and identify emerging patterns. The second author first coded three transcripts then met with the first author through videoconference to discuss the codes, and when there was consensus, she completed the coding of the remaining 11 transcripts. The research team met the second time to discuss the codes and created a table of codes and quotations for each transcript. Next, the research team categorized emerging patterns into broader themes, combined the 19 separate tables into one table of themes and supporting participants' quotations. The research team had a third meeting to discuss and name the themes. The final table with themes, quotations, and clean data (data that had no participants' identifying information) was shared with the advisory team, who were all older adults, to verify the information. The research team (PI, RA, and Advisory Group) ensured they accurately captured the older adults' experiences in their living environment during the pandemic through multiple readings of the transcripts, analyzing data, and meeting frequently. The research team members compared transcripts across the three housing groups involved in the study to identify similarities and differences on participants' experiences in the various living environments during the COVID-19 pandemic.

Rigour

The research team employed different strategies to ensure rigour in the qualitative research to facilitate quality of

the research. The first author, who is an experienced gerontological nurse and researcher, conducted all the interviews. She used reflexivity to consciously identify biases to ensure they did not impact the research process (Puplampu, Matthews, et al., 2020). The research assistant (RA) and the second author, who is a PhD prepared researcher, met frequently with the PI to discuss the data during the analysis and write up. An advisory group of three older adults (two females and a male), representing each of the housing environments, was formed to steer the research along with the PI. The advisory group reviewed the interview guide, verified analyzed data, helped create a narrative video on the findings, and participated in the end of project seminar. All research participants were invited to a virtual knowledge dissemination seminar along with nursing faculty members and students where a breakout room session was used to discuss and verify participants' experiences in their living arrangement during the COVID-19 pandemic.

Ethical Consideration

The University of Regina research ethics board (REB) provided ethics approval to conduct the study. The research team obtained permission from the various housing communities and agency involved in the study. Participants provided informed consent electronically or verbally prior to the interviews. All participants' information were removed from data and pseudonyms were used before sharing research findings with the advisory group, at presentations, and in publications. The professional transcription company guaranteed confidentiality of audiotapes sent for transcription.

FINDINGS

Nineteen older adults took part in the study: nine from private homes, six from assisted living arrangements, and four from the cohousing community. Fourteen of the nineteen participants were between the ages of 65 and 84; fifteen were females and four were males. Most participants had bachelors or masters degrees, were widowed, described their health status as "healthy," and indicated that they did not use professional services. Please refer to Table 1 for demographic data. Five themes emerged from the data: safety in living arrangements, benefits of the pandemic, challenges from the pandemic, support systems, and coping strategies to describe the participants' perceptions of the impact of their living environments on their healthy aging in place during the COVID-19 pandemic.

Safety in Living Arrangements

All participants from the three living environments expressed feeling safe in their housing arrangements during the pandemic. The sub-themes that emerged from this first theme were: "Feeling safe in the living arrangement," and "Safety practices and regulations."

Feeling safe in the living arrangement: The majority of the study participants expressed that they felt safe in their present residence. Participant eight, a female participant in her 70s from an assisted living housing arrangement described her experience:

> *I feel safe here because of the regulations we have and the things that we do. We have adult children who come in to visit, but they have to be screened and wear a mask and, um, [they] can't just come straight to our suite . . .*

Similarly, participants in private homes also felt safe because they did not share facilities or activities with people in most situations. Participant five, a female in her 70s who lives in a private home said, *"I'm home. I get what I like as I am able to be isolated from other people. I don't have to worry about physically distancing. . . we feel that we're safe."* Participants in cohousing arrangements also expressed feeling safe in their building because no one had contracted the coronavirus. For example, a female participant in her 60s from a cohousing residence said, *"we've not caught it and no one close to us has caught it."*

Safety practices and regulations: This second subtheme under safety captured participants' approaches to maintaining safety and preventing infection. Some of the measures participants highlighted included: closing of activity rooms and monitoring temperature of visitors at the front door of their building, stopping social gatherings, and keeping small bubbles of friends and immediate family members. Participant 10, a female in her 60s living in a cohousing residence, shared, *"but as a community, we would institute certain protocols, limiting the number of outsiders or strangers that can access our facility and thereby reducing the danger of bringing COVID into our community."* The older adults, particularly those in private homes, believed that avoiding crowds and social gatherings were additional measures needed to stay safe from being infected. A female participant in her 60s from a private home shared, *"I just quit going out and socializing, eating out, to avoid the contact, to avoid the exposure"* (participant four). Participant one from a private home said, *"I keep a small bubble. It's just my family and one other couple and we had over actually yesterday for supper, and we did it outside."*

Benefits of the Pandemic

This second theme describes the advantages of the COVID-19 pandemic. Many of the participants expressed that the pandemic has increased their self-awareness of infection prevention. A female participant in her 70s from a private home elaborated, *"I mean COVID-19 certainly has the benefits of one, you take into consideration safety, you take into consideration sterilization or cleaning or whatever*

which is interesting" (participant two). Additionally, some of the participants discussed that the lockdown has helped them to be alone; these individuals said they enjoyed being alone. A 90-year-old female participant from an assisted living facility shared, *"I like to be by myself. I like my own space. I'm quite independent. I like to manage things for myself"* (participant 15). Many of the older adults shared that they have gotten to know their neighbours and neighbourhood a bit more during the pandemic. A participant in a private home shared, *"Well, I'm very glad to be in my own home. I have access to everything I need. I have a garden, which is fairly productive. I've gotten to know my neighbors, which I did not know very well before"* (participant 10).

Challenges of the Pandemic

This theme describes a range of unprecedented challenges the COVID-19 pandemic presented to the older adult population. The challenges participants reported are grouped under subthemes: "Noncompliance," "Reduced activities and access to services," "Missed social interactions with family and friends," "Isolation, loneliness, and depression," and "Difficulty working collaboratively online."

Noncompliance: Participants, particularly those living in private homes, expressed their anxiety and helplessness about other members in their building or in the community not adhering to the COVID-19 protocol of wearing a mask and social distancing. Participant 18 from a private home said, *"It concerns me that so many people do not want to wear their masks."* People's limited use of masks was common during the first wave of the pandemic when data for this study was collected.

Reduced activities and access to services: This challenge addressed the various social activities that older adults were engaged in or services they were utilizing that were suspended or permanently stopped during the pandemic. Some participants were companions for their spouses who held membership in gyms as part of their self-management of chronic illness. A female participant in her 70s living in a private home shared about her husband:

> *I know he should and could replace it with walking somewhere else or something. But it's not the same as going to a controlled program where you're monitored and somebody is asking you questions. It's like somebody cares. It's not like just walking down the street.* (participant five)

Some of the participants reported having limited access to services such as medical and dental care, basic home services such as carpentry work, and volunteer opportunities. Participant eight, a 75-year-old female participant in an assisted living building, elaborated, *"limited access with my doctor but also, with other support, medical support services like dental and acquiring [a] hearing aid."* Although in-person medical care was reduced, some older adults expressed that their physicians and other health care professionals took good care of them.

Another major concern that older adults shared was the absence of volunteer opportunities available to them:

> *When I retired, I thought I would become involved in volunteering. And the volunteering has come to a halt. And so I have this need that I need to be productive. . . When I worked, I felt very needed and I felt that I had a purpose. Right now, I can honestly say I don't know what my purpose is.* (participant five, a female in her 70s in a private home)

Missed social interactions with family and friends: The majority of participants expressed how they have missed social interactions with their families and friends. Participant 11 from an assisted living arrangement shared, *"I have missed a lot of birthdays and [missed] Mother's Day, all those things. I think I miss my great grandchildren more."* Many of the older adults discussed how they missed their grandchildren and great grandchildren. A 65-year-old female participant in a cohousing residence said:

> *So not like it is lonely, but I kind of want to see my kids. I have one grandchild and he's in [province A], too, and he's only four. So, it would be nice to actually see him in person, though we do FaceTime, and he's gotten to the point where he thinks Granny is the phone.* (participant 12)

Participant 13, an older adult in an assisted living facility described her feelings as follows: *"The only thing that I would say is that I like to go out to a Church. Now, we have Church here in the building. But I like to go to another building and we are not able to do that now."*

Isolation, loneliness, and depression: A major challenge many participants encountered during the pandemic was the isolation, loneliness, and depression they experienced due to lack of social contact with family members and friends. Participant five, from a private home, shared sentiments indicative of loneliness resulting from isolation, *"I would say it's isolated because we are in our own home and family doesn't come the way they would otherwise. And nobody stays here like, yeah I would say we're fairly isolated."* Participants in private homes reported more feelings of isolation during the pandemic. Some older adults elaborated that they miss travelling, particularly during the winter months. Participant five living in a private home said, *"I'm missing not being able to leave. I have a son in city [A] and one in city [B] and I would have gone to see them. I cannot travel."* Some older adults admitted that during the first

lock down they were slightly depressed, as explained by a 78-year-old female participant in an assisted living facility:

> *Well, sometimes I get a bit depressed, but I work myself out of that one. I've had that before and I just know that I have to get out, do something, go for a walk or go talk to somebody or, that kind of thing. Just not stay in the suite all the time.* (participant eight)

Support System

This theme describes the various sources of support such as family members, friends, work colleagues, and the larger society that play important roles in the healthy aging in place of the older adults particularly during the pandemic. The subthemes that emerged from this main theme are: "Support received from family, friends, and community" and "Support offered to others."

Support received from family, friends, and the community: Participants explained that formal and informal support they received from family, friends, and community members helped them to maintain their quality of life. Participant 15, a 90-year-old female participant in assisted living facility shared, *"I have two daughters in the city and they have been fantastic. They are always bringing groceries. They take me if I have to go anywhere. I'm very well looked after by the family."* Participant 12, a male participant in his 60s, shared how cohousing residents supported each other, *"if there is anything that I need or if somebody else need[s], we just send out emails and whoever in the community happens to read that email first will go to that person's aid. . ."* Besides support from family members, participants from an assisted living facility added that the staff have been very supportive to them. Participant eight, a 78-year-old female participant from an assisted living facility said, *"the staff here is wonderful to us and they do a lot of things, they go out of their way to talk to us and to have . . . just so we have contact with people. . ."* Some participants' support systems have been their friends. Participant four, a female participant in her 60s from a private home, illustrated:

> *I've got some very good friends. Not a lot of friends but the friends I do have, we're really trying to make sure we text, whether we phone just say "How's your day?" "Have a good day," or "Good night."*

Support offered to others: Support offered to friends and family members helped these individuals to stay safe, brought a sense of accomplishment to the older adults, and reduced their feelings of loneliness during the pandemic. Participant 10 shared, *"My son doesn't drive and has been less mobile because we're not taking city transit because of COVID so, he would have to rely on us to drive him."* Another participant in her 60s from a private home who lives with her daughter and her family said, *"I have supported by way of caring for the children in the house, taking them to school and back, and making all the chores for them. This is my support to them"* (participant 16).

Coping Strategies

This theme describes the coping strategies the older adults adopted to address the challenges COVID-19 presented. All the older adults discussed their awareness about having one or more comorbidities, which made them anxious, especially regarding social gatherings. Participant 11, a 93-year-old participant living in an assisted living facility, said, *"My challenge is to keep myself safe and healthy because I know that being 93 years old, probably [I am] more prone than you are or my kids are."* A couple in their 70s living in a private home shared:

> *We have been really careful about being exposed to other people because we know that with pre-existing conditions, that COVID wouldn't just be a simple cold for us. It would probably have much more dire consequences. So, we've been very careful.* (participants six & seven)

Many older adults have coped with the isolation associated with the pandemic by playing indoor games, watching TV, reading, or depending more on technology to connect with their families and friends. Participant eight from an assisted living setting said, *"I've also been able to maintain contact with my children and family, so technology was great to FaceTime and have constant communication with them despite not seeing them in person."* Some participants spent their time engaged in gardening during the spring and summer time. Participant three from a private home shared, *"I just love my home and I love working in my yard and garden. That always keeps me going."* Another key coping strategy of the older adults who participated in the study was their resilience in facing life's challenges. Participant four from a private home said:

> *I had to really stop and take value of what I'm thankful for just so I don't get too depressed or blue, or just feeling sorry for myself because I'm luckier than a lot of people and I have to keep appreciating.*

The findings show that all the older adults felt safe in these three living arrangements. Many of the older adults, especially the older adults living in their private homes, missed human contact and felt a little depressed at the start of the social isolation measures. This study also shows that all of the housing types listed in this paper supported older adults aging in-place in a healthy manner during the pandemic despite differences in perceived levels of loneliness.

DISCUSSION

This study's findings shed light on the three living arrangements: private homes, assisted living facilities, and cohousing communities of older adults. A major highlight from this study is that the older adults from all three types of residences felt safe in their living environments because of protocols, guidelines, and individual measures instituted to reduce the spread of the virus. Other studies have also reported that older adults carefully followed public health directions including physical distancing, hand washing and sanitizing, and wearing of masks to prevent the spread of the infection and remain safe during the pandemic (Chen et al., 2021; Nascimento, 2020). However, the current study is the only one that examines older adults' experiences from three living environments and reports on older adults' feelings of safety in these living arrangements during the first wave of the pandemic.

A key benefit of the pandemic is that the older adults in our study became very aware of their comorbidity or comorbidities and vulnerability, a phenomenon that other researchers have noted in their studies conducted during the pandemic (Gonçalves et al., 2021; Nascimento, 2020). Another advantage of the pandemic the older adults reported was that they had become more aware of their neighbours and their neighbourhoods since interprovincial and cross border travels were restricted. Similarly, older adults have increased their interest and use of technology such as the telephone, the internet, Zoom as well as social media platforms including WhatsApp and Facebook to connect with families, friends, and access services in the community. Other research findings on older adults increased use of technology and social media corroborated with the current study's findings (Chen et al., 2021; Gonçalves et al., 2021; Nascimento, 2020).

The social distancing measures presented unique challenges to older adults, including missing social interaction, isolation, loneliness, and some level of depression with older adults in private homes feeling more depressed compared with those living in an assisted living and cohousing buildings, which align with findings from other research during the COVID-19 pandemic (Chen et al., 2021; Gonçalves et al., 2021; Nascimento, 2020). The participants discussed that they missed their grandchildren and family events such as birthdays and Mother's Day celebrations. Participants in private homes expressed their frustration with limited access to technical services such as carpenters during the pandemic. While some participants in the current study missed going to in-person church, the older adults in Gonçalves et al.'s paper (2021) were involved in virtual church activities and depended on their faith as a coping strategy by praying a lot to God to help them overcome their fear of the coronavirus which they described as "very powerful … and very dangerous" (p. 6).

Many older adults coped with the challenges the pandemic presented through use of technology and social media platforms as discussed above. Some participants were involved in gardening, calling friends and families to check on them, keeping small bubbles of friends, going for walks, completing projects, engaging in art work, taking a course, babysitting grandchildren, and being appreciative of what they have, which corroborates another study on older adults during the pandemic (Chen et al., 2021). Older adults elaborated that supporting others brought a sense of accomplishment and usefulness during the pandemic especially when volunteer services were closed; this finding aligns with Chen et al.'s (2021) findings.

Implications for Gerontological Nursing

An important implication from the findings of this research is the increased awareness provided to gerontological nurses and other service providers on the impact of health, social, psychological, and technological strategies, including adherence to public health guidelines, which older adults or assisted living staff implemented to ensure safety and wellbeing. Secondly, this study's findings highlight the importance of social interaction, mental health, and spirituality to older adults particularly during complex life experiences such as COVID-19 pandemic, in order to promote their healthy aging (Dellasega et al., 2007). The findings will enable researchers, academics, students, service providers including gerontological nurses, and the public to comprehend, empathize, and appreciate older adults' experiences and coping strategies employed during the COVID-19 pandemic to maintain their healthy aging in place.

Recommendation for Future Research

It is crucial that participatory action research studies that involve older adults in all stages of the research are conducted to review society policies' impact on older adults as we recover from the pandemic to alleviate social isolation among older adults, which was a public health concern prior to the pandemic (Rotermann, 2017; The National Seniors Council, 2014) and has intensified during the pandemic. With the pandemic entering into a fourth wave in many parts of Canada, we recommend a longitudinal study to further examine the impact of COVID-19 on older adults, their families, and caregivers.

LIMITATIONS

The main limitations of the study are the one-time data collection and small sample size. However, establishing an advisory group and presenting findings at the end of project seminar enabled the research team to verify data with participants and ensured we captured participants' experiences during the first wave of the pandemic.

CONCLUSION

COVID-19 pandemic has been very stressful for all Canadians, particularly older adults. Through this study, the researchers have shed light on the fact that private homes, cohousing, and assisted living are all safe environments for older adults. Older adults in all the three environments revealed feeling lonely during the pandemic with older adults from private homes feeling lonelier. The older adults employed diverse coping skills to maintain their healthy aging during the pandemic. We recommend a longitudinal study to examine the effects of the pandemic on older adults' wellbeing as the pandemic continues and to also identify pandemic recovery strategies to enhance the healthy aging of older adults.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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Table 1
Demographic Data

Item	Number (N)	Percentage (%)
Age		
65-74	7	37
75-84	7	37
85-94	2	11
95 and above	3	16
Gender		
Male	4	21
Female	15	79
Level of education		
Less than grade 12	1	5
Grade 12	2	11
Diploma	7	37
Bachelor	6	32
Masters	3	16
Marital status		
Single	3	16
Married	6	32
Widowed	7	37
Other	3	16
Living arrangement		
Private home	9	47
Cohousing	4	21
Assisted living	6	32
Perception of health (Self-report)		
Very healthy	3	16
Healthy	15	79
Not healthy	1	5
Use of Professional Services such as meals on wheels; home care services		
Yes	3	16
No	16	84

Table 2
Themes and Subthemes

Safety in the Living Environment	• Feeling safe in living arrangement • Safety practices and regulations
Benefits of the Pandemic	• Self-awareness • Increased independence • Got to know neighbours • Improved mental health • Reduced expenditure
Challenges from the Pandemic	• Noncompliance • Reduced activities and access to services • Missed social interactions with family and friends • Isolation, loneliness, and depression • Difficult working collaboratively online
Support System	• Support received from family, friends, and service providers • Support offered to others
Coping Strategies	• Awareness of comorbidity • Play game, watch TV, and read books • Technology • Gardening • Resilience

WHY WRITE? SHARE YOUR EXPERIENCES THROUGH A LETTER TO THE EDITOR, AN OP-ED OR CREATIVE WRITING

Roslyn M. Compton PhD RN, Assistant Professor, College of Nursing, University of Saskatchewan, Katherine M. Ottley MA PhD(c), Graduate Psychology Student, University of Saskatchewan, Thomas Qiao BA, Undergraduate Psychology Student, University of Saskatchewan.

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ABSTRACT

An associate journal editor (Roslyn M. Compton), a graduate psychology student (Katherine (Katie), M. Ottley), and an undergraduate psychology student (Thomas Qiao), explored their experiences and understandings of writing Letters to the Editor, Op-Eds, and creative writing pieces. Roslyn, Katie, and Thomas are members of the Saskatchewan Long-Term Care Network, an independent collective of family members, researchers, clinicians, and trainees that formed in March 2020 and work together to provide evidence- and experience-informed strategies to long-term care (LTC) stakeholders during the pandemic and beyond. This opportunity to write together was initiated by gerontological nurses asking about these different forms of publications and how to write them. The following discussion over WebEx is our learnings of the different types of writings, their requirements, and the benefits and risks of publishing them.

WHAT IS A *LETTER TO THE EDITOR*?

Roslyn shared that a *Letter to the Editor* is a persuasive argument, which was further discussed by Katie to indicate that this automatically means responding to something, and probably something from a particular publication. Thomas added that an opposite idea does not have to be presented. You can provide an idea that resonates with the original article or publication, for example, indicating you have a shared experience. Writers can use both published information and lived experiences to support their arguments. Katie noted that a *Letter to the Editor* needs a focus. Roslyn further suggested using the opening sentence to convey your emotional response to the audience, e.g., "I'm greatly distressed by the current events in LTC across Canada." Thomas articulated that relevance is important, including how recent the information is.

To our knowledge, the length of a *Letter to the Editor* is very short. From Thomas's research of different journals, some journal submissions are limited to 150 words, others to 300 words (American Journal of Nursing, n.d.). Seven hundred words is the maximum number of words for Perspectives, the e-journal for the Canadian Gerontological Nursing Association. There are a wide range of academic journals that will accept *Letters to the Editor*. Further, newspapers and community newsletters will also accept *Letters to the Editor* or similar submissions. Multiple authors can be included, though not a large group of authors, generally no more than three. References should also be limited to five or fewer.

AND THEN, THERE IS THE *OP-ED*

At the beginning of our conversation, Roslyn shared she learned *Op-Ed* is an abbreviation for *Opposite Editorial*. The title gives writer's permission to have an opinion. What nurses write about will often be guided by the places where they are planning to publish. With this Katie added, an *Op-Ed* gives a little bit more freedom than a Letter to the Editor; it does not have to be in response to something already published. Katie saw freedom in that she could voice her opinion backed up with various pieces of evidence. Furthermore, Thomas indicated that in an *Op-Ed*, you should use more than your lived experience as evidence. Some people do not recommend including lived experience at all, because it allows more space to provide concrete evidence and to be more persuasive. Roslyn shared that a good *Op-Ed* is an entry into a debate. The debate is with the experts, dissenters, and survivors. The goal is to start a strong conversation. In an *Op-Ed*, writers have an opportunity to give people facts and information as well as an opinion. Maybe readers will think about it differently, or at least be more engaged with the material they are reading.

Thomas equated the format of an *Op-Ed* with an argumentative essay that you might have written in high school or university. Generally, writers have between 500 and 800 words, so there is space to structure an *Op-Ed* with an introduction, supporting paragraphs and a conclusion. The introduction should set the context for what is being written about. The supporting paragraphs provide evidence for an argument, and the conclusion generally includes recommendations based on the evidence provided and, in some cases, a professional opinion. For example, when offering an *Op-Ed* related to public health, a physician or a nurse might indicate their relevant professional experience and knowledge. This can help people take the advice more seriously.

NOW FOR THE FUN PIECE: *CREATIVE WRITING*

Roslyn noted that creative writing is a powerful way of connecting with the reader when you are passionate about something: your experience is valuable. Katie articulated that creative writing for publication does not have to be scary. However, it does take on a different form than writing academically. Thomas proposed creative writing gives a bit more flexibility, an ability to express yourself. The content can be a little bit more nuanced, more reflexive. One example of creative writing is bringing together multiple perspectives, which might have the advantage of helping to protect participants from abuse or changes in their care because they shared their stories. Roslyn mentioned that the genesis of a piece of creative writing might be to think about something differently. Thomas indicated another advantage to creative writing is that there is flexibility in where the piece is published. Roslyn acknowledged in creative writing, there's a lot of white space, which is intentional space left between lines and among words (Botha, 2016). The white space provides somewhere for readers to pause, think, and maybe begin to tell their stories alongside yours.

The conversation then moved to a discussion of risk when publishing. Roslyn noted that you must be able to stand behind what you have written and be aware of the risks, such as those to your professional standing. For example, you must attend to the possibility that what you want to write may conflict with your professional responsibilities or licensing bodies leading to disciplinary action. Katie asked us to consider that who we are in the world will change how we perceive risk, and that sometimes this means deferring to people outside your profession to publish a risky article, such as a journalist. Thomas described the role of the audience in experiences of risk. He suggested publishing for some audiences might require more risk. There are options where to publish; maybe choose a safer place for your piece such as a community newsletter or a local newspaper. One way of helping to mediate risk is to ask a colleague or trusted friend to review your work. They might read and understand what you have written differently.

WHY SHOULD WE ENCOURAGE WRITING FOR PUBLICATION?

We posed the above question to our group. Thomas shared we write because it is important to get the message out. "We want to hear stories because our healthcare system really needs change. We need things to happen and, without people's opinions, input, and sharing of experiences, nothing will happen." Stories will help shape direction and purpose. Roslyn voiced support for the need for collective voices and raising awareness when opinions differ, and Katie emphasized the solidarity that writing can bring. Thomas added, you aren't alone in being that frontline worker in the middle of the pandemic; if the sharing of experiences doesn't occur, then it's really isolating. Seeing something in writing can help people, especially the marginalized and underrepresented, to see they are not alone in their experiences. As gerontological nurses, we must share our knowledge and experiences to influence change and maximize quality of life. We can achieve this through writing and publishing.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.