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Exploring Older People's Experiences of Shielding During the COVID-19 Pandemic.

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Exploring older people's experiences of shielding during COVID-19

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Exploring older people's experiences of shielding during COVID-19 Foreword.



When Covid-19 was first detected in Wuhan in China in late 2019, little did any of us think that it would have a profound impact on all of our lives. On 11th March, 2020, the World Health Organisation declared the Covid-19 outbreak a worldwide pandemic. This, coincidentally, was the same date that Ireland's first recorded Covid-related death occurred. On March 27th, Ireland was placed on full lockdown, which included cocooning or shielding, with those aged 70 years and over confined to their homes. The lockdown also resulted in curtailment of many health and social services, including home care, day care and safeguarding services. It was recognised early in the pandemic that older people and those with underlying conditions were at particular risk of severe illness or death from Covid-19. Elements of the lockdown, including shielding, were seen as methods of limiting the spread of the disease and protecting older people.

There is little doubt that shielding has helped to limit the spread of the disease and has certainly saved lives. However, there have also been significant anecdotal evidence indicating that restrictions and shielding have had unintended consequences. Safeguarding Ireland was particularly interested in exploring what these consequences were and the extent to which they impacted on older people – hence Safeguarding Ireland's support for this research.

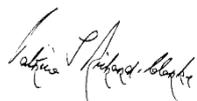
The authors of this study, through their research, have demonstrated that the restrictions that were introduced to limit the spread of the pandemic and protect health have resulted in social isolation, exclusion, loneliness and boredom, with impacts on the quality of life, and physical and mental health of older people. They have used the experiences of a sample group of older people to tell a story of disrupted lives, sadness, loneliness and a raised consciousness of vulnerabilities. They have also outlined mechanisms used for coping with the restrictions. However, as the authors point out, the *'sample does not represent the experiences of older*

people who have heavy dependence on others, those whose services were withdrawn or those with cognitive challenges'. In addition, the authors point out that, while many of the sample participants' resilience and capacity to cope was enhanced by engagement with technology, many older people, particularly those over 80 years of age, do not have access to the internet. Therefore, it is reasonable to assume that the very old and the most dependent suffered much greater social isolation, exclusion, loneliness, a reduced quality of life and mental and physical ill-health during the lockdowns.

In relation to the perpetration of abuse during the pandemic, this report points to the increase in demands on Irish family violence services. It also, through its reference to the literature, references the United Nations view that violence against women is a 'shadow pandemic', while the Lancet identified elder abuse as the 'second shadow pandemic'.

This paper is one that will be of interest to everyone and particularly policy-makers and those involved in the planning and delivery of health and social services for older people. It is a timely and important reminder of responses that are needed, not only to the pandemic itself, but also to the unintended effects of efforts to limit the spread of disease. Health and well-being are not just about being free from disease but also encompass less tangible, but no less important, matters such as social connectedness, interdependencies and independence.

Patricia Rickard-Clarke,



Chair,
Safeguarding Ireland.

KEY FINDINGS

- Older people made substantial changes to their daily lives to comply with the COVID-19 shielding guidance.
- COVID-19 had significant impacts on the health of older people in the community.
- Social capital was demonstrated as compensatory measures were adopted to daily lives.
- Older people reported a general stoic approach to living in the pandemic and they demonstrated resilience in multiple ways.
- The use of technology assisted in managing social and practical activities, however, its use, satisfaction and familiarity differed within the participants in the study.
- Older people need more integrated support systems which maintain their personal, health and social needs.
- Consideration needs to be given to pandemic related information to avoid information fatigue, misinformation, and confusion.
- Post-pandemic rehabilitation will be required to focus on restoring lost physical ability and address the consequences of social isolation and loneliness.
- There is a need to ensure that ageist approaches do not underpin guidance. The rights of autonomy and self-determination need to be central considerations in future similar crises.

Chapter 1 Background and Context

INTRODUCTION

COVID-19, (Severe Acute Respiratory Syndrome (SARS) or SARS CoV-2), has resulted in rapid, large scale infection rates as well as significant death rates and an economic crisis for many countries (Lim *et al.*, 2020). As COVID-19 spread across the globe, the World Health Organisation (WHO) declared a pandemic on March 11th, 2020. Knowledge about COVID-19 emerged quickly, with it initially becoming clear that certain population groups presented a higher risk in terms of morbidity severity and mortality rates. These groups included older people aged 70 years and above, those living with dementia and people with certain risk related medical conditions (i.e. diabetes, solid organ transplant recipients, specific cancers, obesity, respiratory illness, people who are immunocompromised) (Wang *et al.*, 2020, Akbar & Gilroy, 2020; Apicella *et al.*, 2020; Tay & Harwood, 2020, Cohen & Tavares, 2020). Moreover, COVID-19's impact transcended the domains of health and social norms with major impacts on national economies (Miller, 2020).

Within the context of an increasing prevalence of COVID-19, various governments initiated public health measures, some with supporting legislation, to limit transmission of the virus. Many countries, including Ireland, mandated 'lockdowns' in the initial aftermath of the pandemic declaration to try to limit rising infection rates. A common element of public health advice was for older people and those medically at risk to shield, also described as stay at home orders, cocooning or sheltering in place¹. This entailed those individuals remaining at home and limiting face-to-face interactions. In the context of such unprecedented public health measures, this study aimed to explore the impact of the COVID-19 public health measures on the experience of older people who live in the community setting in the Republic of Ireland. This chapter provides the background and context to the study by overviewing literature pertinent to the subject area.

¹ For the purposes of this study, the term shielding is used.

COVID-19

In December 2019, a new coronavirus, Severe Acute Respiratory Syndrome (SARS), was identified in Wuhan, China. COVID-19 is from a family of viruses that cause diseases in animals, with the first serious SARS occurring in 2003. To date, there have been at least seven SARS viruses that have transferred to human beings. Most of these infections have caused mild symptoms and have not had the same severe global impact as COVID-19 has had (Lim *et al.*, 2020). There have been several major pandemics recorded in history, with one of the most notable being the Spanish Flu, which claimed approximately 500 million lives between 1918 and 1920. On 19th August 2021, the global number of deaths attributable to COVID-19 was 4,393,138 (John Hopkins University, 2021) with Ireland's case fatality rate recorded as 2.0 percent. At this time, Mexico reports the highest case fatality of 9.1 percent.

COVID-19 has a higher reproduction number than influenza (Verity *et al.*, 2020; Heid *et al.*, 2020; WHO, 2020a). For instance, the seasonal flu is reported to have an infection mortality proportion of 0.039 percent as compared to COVID-19 at 0.23 percent (Baker & Wilson, 2020; Lee *et al.*, 2020a; Ioannidis, 2021). People can be infected with COVID-19 and have no symptoms, not have symptoms for several days, may only have mild symptoms or may progress to more severe illness. Infection results in a major immune response termed a cytokine storm and possible symptoms are detailed in table 1.

Table 1: Potential symptoms of COVID-19

General symptoms (Chiappelli, 2020)	Additional symptoms which may present in older people (Solanki, 2020)
Initial fever	Diarrhoea
Dyspnoea	Falls
Pneumonia	Reduced appetite
Cardio-vascular failure	Hypoxia may present even in the absence of
Gastrointestinal upset	breathlessness
Myalgia	
Malaise	
Various neurological symptoms	

Severe infection can lead to hospitalisation, delirium, intensive care, ventilation and death. The estimated case fatality rate is 10 percent, and older people have been severely impacted, particularly in long-term care environments (Verity *et al.*, 2020; Miller, 2020).

COVID-19 is transmitted through close contact with other people, although the virus has also been shown to survive on objects for several days. Four factors are relevant in pandemic control: duration, opportunity, transmission, and susceptibility (Kucharski, 2020). Globally, public health measures initially focused on knowledge of and responses to the first three factors, while the introduction of vaccines for COVID-19 has significantly impacted on individuals' susceptibility in terms of developing protection, though acquired/adaptive active immunity.

Like other virus types, particular sub-groups in the population have a higher susceptibility to COVID-19. Two groups are at particular risk of getting severe COVID-19 infection and exhibit higher mortality rates; these are older people and people with underlying medical conditions (WHO, 2020; Fakhroo *et al.*, 2021), such as diabetes, respiratory diseases, and obesity. The physiological changes of ageing in terms of both the respiratory and immune systems increase susceptibility risk. For example, both the respiratory and immune systems become less effective as the ageing process occurs (Weyand & Goronzy 2016; Knight & Nigam, 2017). In addition, it has been suggested that social inequalities impact vulnerability to COVID-19 infection; for example, black, minority and ethnic groups, older people, women, those living in poverty and the disabled have been impacted disproportionately (World Economic Forum, 2020; Age UK, 2020; Petretto & Pili, 2020; Rivera-Hernandez *et al.*, 2021).

In terms of the impact on older people, the Centre for Disease Control (CDC, 2021a) notes that eight out of ten COVID-19 deaths in the United States (US) were in the 65 years and over age groups, while up until November 6th, 2020, nine out of ten deaths were reported in the 65 years and older age groups in the United Kingdom (UK) (Office for National Statistics, 2020). The Irish Central Statistics Office (2021) report that from March 2020 to March 2021, 56 percent of COVID-19 related hospitalisations were in the 65 years and older age group, while this cohort represented 87 percent of deaths. Using a reference group of 5-17 years of age, the CDC (2021) identify that people aged 65-74 years are 40 times more likely to be

hospitalised and 1300 times more likely to die. For those over 85 years, the figures increase substantially, with hospitalisation being 95 times more likely, while death is 8700 times more likely. In many countries, the morbidity burden has also been disproportionate in the older age groups, with substantial deaths in long-term care facilities (Lloyd-Sherlock *et al.*, 2020).

Another important issue related to COVID-19 is the persistence of symptoms. Long COVID-19 occurs when there are effects which are prolonged after the infection period (longer than 12 weeks and not explained by an alternative diagnosis), or where the symptoms last longer than expected (Mahase, 2020). In one UK study (n=4182), where data were collected via app users, over 13 percent of patients demonstrated prolonged COVID-19 symptoms or effects (Sudre *et al.*, 2021), including fatigue and intermittent headaches as common with dyspnoea and anosmia also reported. Being female and in the older age category with a history of asthma, were identified as risk factors, demonstrating a strong association to long COVID-19 (Sudre *et al.*, 2021).

IRELAND'S COVID-19 JOURNEY

Ireland identified its first case of COVID-19 on the 29th February 2020, with the first infection wave from 1/3/20 to 1/8/20. Figure 1 outlines the COVID-19 response in Ireland.

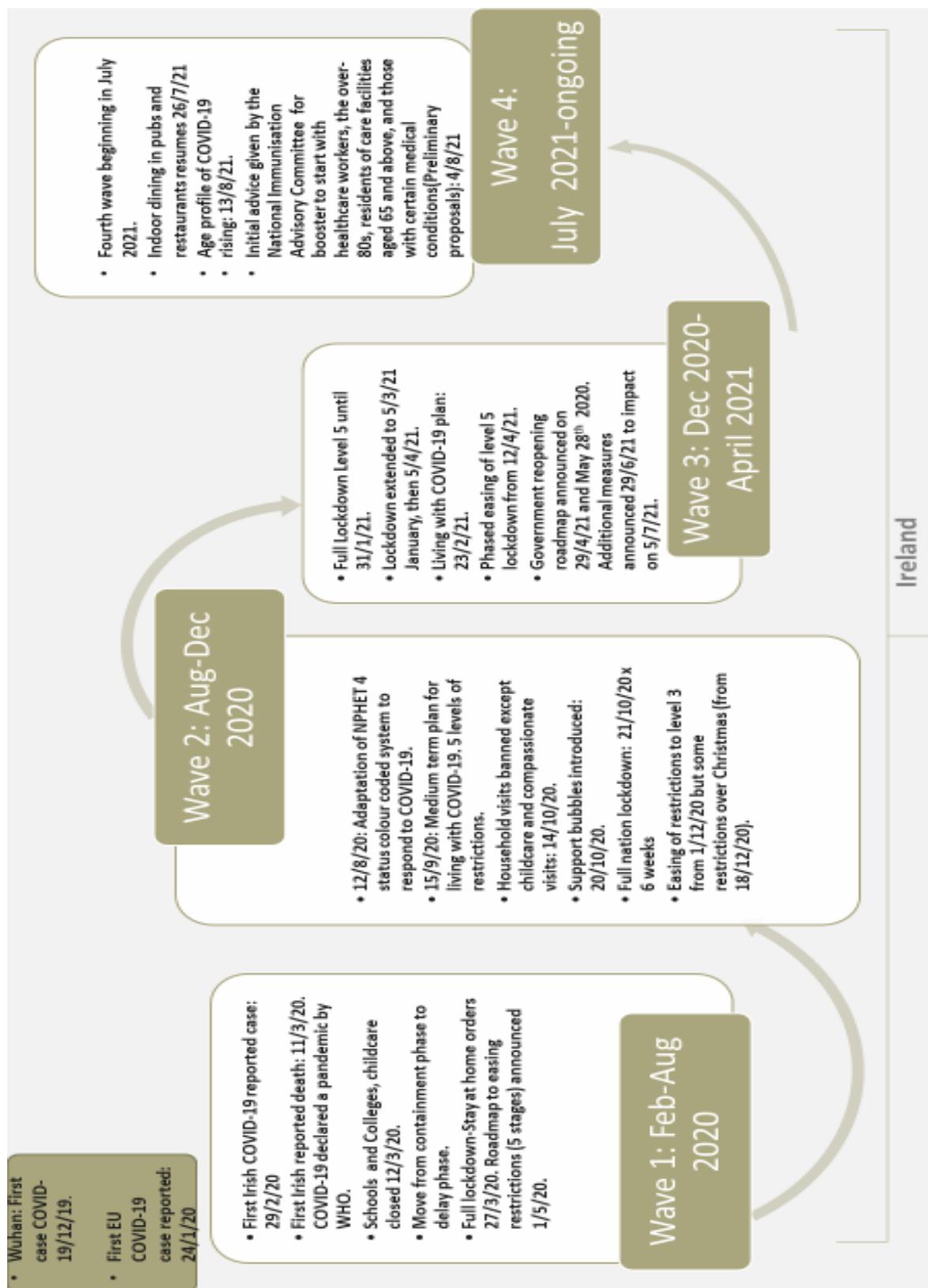


Figure 1: COVID-19 timeline for Ireland

The first COVID-19 related death in Ireland was recorded on March 11th, 2020. Schools, colleges and childcare facilities were closed on March 12th with a subsequent 'stay at home' recommendation on 27th March 2020. Initial public health advice included non-essential retail closures, working from home, if possible, a two-metre distancing policy, a two-kilometre travel restriction, social gathering limitations as well as establishing mass testing and tracing centres. In addition, visitor restrictions were implemented in nursing homes. Later, in August 2020, legislation under amendments to the Health Act (1947) mandated the wearing of face masks in shops, on transport, at hospital appointments and other areas of essential congregation. In addition, an intensive programme of track and trace commenced to try to identify potential infections early so self-isolation could commence for the individual and close contacts. From early in the pandemic, the focus was to flatten the curve, so health systems would not be overwhelmed. Like other countries, this translated into efforts to minimise the spread rate of the virus infection, so care services could provide care within service capacity.

Throughout the pandemic, Health Service Executive (HSE) public health advice was that older people and those who were considered medically at risk, would shield (<https://www2.hse.ie/conditions/covid19/>). When the first wave of COVID-19 infection was deemed on the decline, with dropping reproduction numbers, reduced screen positive rates and lowered related deaths, some of the public health restrictions were relaxed. However, a second COVID-19 infection wave was heralded by increases again in infection reproduction rates. Initially, a reintroduction of restrictions was focused on a county level (figure 1) and on 15th September 2020, the government introduced five levels of restrictions (the fifth being the most restrictive). At midnight October 21st, 2020, the country entered a further six-week period of higher restrictions. Once more, those aged over 70 years and those who were deemed as extremely medically at risk were advised to shield. However, government guidelines were more flexible for older people than in the first wave and recognised that everyone has self-determination regarding the appropriateness of shielding for themselves. In the later stages of the second wave of the pandemic (October 2020), the Irish Government promoted the practice of creating support bubbles to alleviate isolation. This meant that people living alone, carers, or people with live-in carers could have social interaction with one

other household, providing that household did not share a bubble with others (Department of An Taoiseach, 2020).

Although the restrictions relaxed to enable commercial activity, dining out and limited social interaction, the impact of this heralded a third infection wave (from December 2020). Consequently, level five restrictions were reintroduced on December 30th, 2021, with a plan to gradually lift restrictions being communicated by the Taoiseach, Michael Martin, on April 1st, 2021. At the point of writing this report, Ireland was in a fourth pandemic wave, and while the age range of those testing positive for COVID-19 and those in hospitals had lowered, the age profile has started to demonstrate a rise with 6.5 percent of cases on the COVID-19 Care Tracker being identified as people aged 65 years and over (HPSC, 2021b). However, as Ireland enters a second winter of the pandemic, the Government has operationalised a plan to deliver vaccine boosters to at risk groups and to reopen society.

Older people's experiences of the pandemic

In April 2021, there was an estimated 742,300 older people living in Ireland - a rise of 112,500 since the 2016 census (CSO, 2021a). From a geographical distribution, the majority live in the Dublin region with the lowest volume residing in the midland areas. Like many other countries, most older people in Ireland live in the community environment with approximately 30,000 people living in residential care (Department of Health, 2020a). In the community setting, one in eight people over the age of 50 years report a functional limitation with 60 percent receiving assistance from formal services or informal supports, such as family (McGarrigle & Kenny, 2020). In addition, older people are also reported to provide support for family, neighbours or friends (McGarrigle & Kenny, 2020) demonstrating the important contributions older people make to the social fabric of Irish society.

While older people's experiences of the pandemic are diverse, research has shown that all aspects of health and social experiences have been interlinked (Baker & Clarke, 2020). These include the impacts in relation to the older person's well-being, namely, related to quality of life particularly in the context of the experience of loneliness and social isolation, mental health, as well as physical activity and health. In addition, the impact of public health

restrictions has demanded a curtailment of service provision and increased safeguarding concerns.

Quality of life (QoL)

The World Health Organisation defines QoL as:

“...an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (WHO 1997:1).

QoL is integrally linked to social isolation, loneliness, mental health and physical activity and health as well as social connection, supportive relationships, social activities, social support, and the experience of loneliness (van Orden *et al.*, 2020; Ward *et al.*, 2021; Bailey *et al.*, 2021). Satisfaction with social interaction is a key variable for wellbeing (Macdonald & Hülür, 2021; Siette *et al.*, 2021). McGarrigle and Ward (2018) report that older people in Ireland generally report a high QoL, although ratings decline after 80 years. Data has shown that the QoL of older people has been impacted during the pandemic and this reduction is associated with poorer physical and mental health as well as an increased experience of loneliness (Bailey *et al.*, 2021). Thus, QoL has been negatively impacted by the loneliness of the pandemic, particularly related to participating in one's own environment (control domain) (Ward *et al.*, 2021). Normal activities such as using public transport and older people undertaking their own shopping were also impacted negatively (Bailey *et al.*, 2021). In addition, the severity of depression is linked to a poorer QoL both before and during the pandemic (Sivertsen *et al.*, 2015; Siette *et al.*, 2021).

Social isolation and loneliness

Older people have been considered at high risk of mental health consequences of the pandemic, chiefly due to public health advice regarding social distancing, shielding (Galea *et al.*, 2020; González-Sanguino *et al.*, 2020), lack of physical activity (Pérez *et al.*, 2021) and rapid transmission of infection and high death rate (Yang *et al.*, 2020). In addition, older people experiencing social isolation and/or experiencing loneliness have increased reactivity to stress and demonstrate greater levels of anxiety, depression, physical pain as well as functional and cognitive decline and a higher risk of admission to residential care (Holwerda

et al., 2013; Saito *et al.*, 2015; Courtin & Kapp, 2017; No isolation, 2018; Gyasi *et al.*, 2019; Read *et al.*, 2020; Krendl & Perry, 2021).

Living alone has been identified as a risk factor for contracting COVID-19 (Local Government Association, 2020). While some COVID-19 research indicates increases in loneliness of older people without any mental health effect (van Tilburg *et al.*, 2020), the consequence of public health measures, particularly shielding, have been noted in other studies as having an impact on emotional and mental health as well as resilience, mainly in the context of its prolonged duration (Vahia *et al.*, 2020; Roy *et al.*, 2020; Hamm *et al.*, 2020; Plagg *et al.*, 2020), pre-existence of poor self-rated health or when older people have infected family or friends (Liang *et al.*, 2021). Moreover, the number of restrictions also has an impact on the experience of loneliness in older people (Stolz *et al.*, 2021).

Prior to the pandemic, almost one third of Irish people aged 50 years and above experienced emotional loneliness at least some of the time while seven percent were often lonely (Ward *et al.*, 2019). Those over 75 years and those living alone reported higher levels of loneliness (Ward *et al.*, 2019). However, the emotional impact of shielding has been stark for older people. An Irish study (Bailey *et al.*, 2021) indicated that over half of the respondents in the study (n=150) had reduced their contact with family with one in five indicating that they had not left their homes since the introduction of restrictive measures. Sixty percent limited activities outside their homes. Although older people reduced their face-to-face social interactions with friends, an Australian longitudinal survey study with 21 older people receiving home care in New South Wales (Siette *et al.*, 2021) indicated that there was a lower quality of life during the pandemic as compared to previous years. However, the frequency of respondents' social interaction had not changed with family and friends and telephone communication constituted the most common mode of connection. Some studies from the US demonstrate older people have had a better level of resilience than younger age groups during the pandemic (Czeisler *et al.*, 2020; AARP, 2020), particularly if the older person enjoys close, meaningful relationships and good social support (van Tilburg *et al.*, 2020; Levkovich *et al.*, 2021).

MENTAL HEALTH

Studies have identified diverse findings in relation to the mental health of older people in the pandemic representing the heterogeneity of the older population (Vahia *et al.*, 2020). While the CSO (2020) identifies higher levels of loneliness, downheartedness and depression in younger age groups, such experiences were also reported in the 55-69 and 70 years and older groups with 32.4 percent reporting a negative impact on mental health (CSO, 2021b). Within the pandemic period, older people were considered to have lower stress reactivity and higher emotional regulation than their younger counterparts (Vahia *et al.*, 2020; AARP, 2020, Czeisler *et al.*, 2020) as well as lower levels of post-traumatic stress disorder (González-Sanguino *et al.*, 2020). Pandemic related stress and anxiety have been heightened in older people's experiences (Sepúlveda-Loyola *et al.*, 2020), particularly those living with chronic illness (Gorrochategi *et al.*, 2020; Levkovich *et al.*, 2021). In one Chinese study of older people, it was found that there were lower levels of depression in those who had a higher socio-economic status or high levels of individual precautionary behaviour (ie hand washing, wearing a mask etc) (Kivi *et al.*, 2021; Liang *et al.*, 2021). Equally, in an Irish study, there was higher levels of pandemic experienced depression reported by older people who had either no primary level education or primary education as opposed to those with a third level or higher education level (DeLooze *et al.*, 2021). Since the onset of COVID-19, approximately one quarter of older Irish people reported depressive symptoms with depression being highest in females, those living alone, those in urban areas and those with a primary school education (Ward *et al.*, 2021).

An Israeli study of older residents living in continuing care retirement communities reported that the participants considered themselves in a general better position within the COVID-19 pandemic than others of a similar age (i.e. in a nursing home) yet argued that they were prisoners of their age, and this could lead to declines in mental health (Ayalon & Avidor, 2021). In addition, participants observed younger generations could engage in less restrictive lives (Ayalon & Avidor, 2021). This concurs with findings by Smith *et al.* (2020), which point to a social connectivity paradox, where human connection is particularly needed in a time of shielding. Therefore, there is a delicate balance of protection from infection versus a decline in well-being and the need to protect autonomy to foster emotional resilience (Ayalon &

Avidor, 2021; Clarfield *et al.*, 2020). Conversely, a mixed method study in the US found that older people with major depressive disorders (n=73) were coping adequately and considered adhering to social isolation advice as preferable to the risk of contracting COVID-19 with results also highlighting resilience to related stress (Hamm *et al.*, 2020). This concurs with findings in a Spanish study (Gorrochategi *et al.*, 2020), however, the data for both studies were collected relatively early in the pandemic, and in the US study, shielding was only in place for approximately three weeks.

In Ireland, ALONE, a charitable organisation who work with older people who are socially isolated, homeless, living in poverty or in crisis, received 26,174 calls to its helpline from March 9th to July 5th, 2020. Three quarters of the calls were from older people living alone, while 55 percent of calls were from the over 70 age group. The commonest reason for calling was emotional support and physical health support, with an increase in callers reporting suicidal ideation (ALONE, 2020). In a survey by Bailey *et al.* (2021), 150 people aged 70 years or older attending an older person ambulatory service in a large urban hospital in Dublin were surveyed to explore the impact of the pandemic. Forty percent reported negative mental health impacts since the commencement of shielding. This included loneliness, particularly if living alone or experiencing low mood, worry and anxiety. This concurs with a report from the US where social isolation, loneliness, and negative emotions (frustration, stress, anxiety etc) were reported by six in ten people aged 50 years or over (AARP, 2020). In addition, worry about oneself, the future, worry about others and access to supplies were tangible concerns for older respondents (Heid *et al.*, 2021; Banerjee *et al.*, 2020). Higher levels of worry about the pandemic were further reported in other studies (Roy *et al.*, 2020; Kotwal *et al.*, 2021), and worry could be aggravated by intensified sensitivities of death and dying (Webb, 2021). Worry could also be amplified via information overload or misinformation. Older Irish people's concerns are evidenced by many seeking COVID-19 information, but mainly from national broadcasters and newspapers rather than official Health Service Executive or Department of Health websites (Ward *et al.*, 2021). Being scared could also be triggered by the media, particularly in the context of "information pollution" (Banerjee *et al.*, 2020:5). Portacolone *et al.* (2021) also points to the difficulty of deciphering true information from misinformation and naively believing misleading material, while it was noted that coping can be fostered through virtual religious events, exercise and taking precautions.

Challenges also relate to older people living with cognitive impairment. Those living alone may be at high risk of self-neglect and falls with precarity (a chronic uncertainty in daily life due to compounding pressures in the context of maintaining independence) increasing in crises such as the pandemic (Portacolone *et al.*, 2021). An Argentinian study indicated that people living with dementia had worsening anxiety, insomnia, depression, increased levels of responsive behaviours and gait disturbances, while the use of psychotropic medications rose (Lim *et al.*, 2020; Cohen *et al.*, 2020). In Ireland, people living with dementia have experienced challenges such as limitations or cessation in services leading to a loss of routine, increased responsive behaviours and an exacerbation of loneliness and social isolation (Alzheimers' Society of Ireland, 2020). Consequently, for people living with cognitive impairment, an important support is access to essential resources, family support and home care, yet access could prove difficult, exacerbating precarity, particularly for those living alone (Portacolone *et al.*, 2021).

PHYSICAL ACTIVITY AND HEALTH

Physical activity has a positive impact on health and contributes to functional ability and optimal ageing (Sepúlveda-Loyola *et al.*, 2020). Loss of activity represents a challenge for older people in the pandemic, predominantly in relation to the reduced pursuit of leisure activities, travelling, going to the gym and general freedom of movement (Heid *et al.*, 2021) with compromises likely in cardiovascular and respiratory systems as well as in muscle strength and functional ability (Pelicioni & Lord, 2020; DeBaise *et al.*, 2020; Pérez *et al.*, 2021). A loss of physical activity, particularly abruptly, results in an exacerbation of age-related muscle wastage and increases multi-morbidity risk (Roschel *et al.*, 2020). Thus, reducing activity could exacerbate existing physical health challenges, as one in eight adults in Ireland report a functional limitation, with many older people receiving either informal or formal support (McGarrigle & Kenny, 2020). Public health restrictions in the pandemic meant that previous activities were curtailed as the over 70s and those medically at risk were advised to remain in their homes. One study indicated that the average decrease in physical activity of older people was 65 minutes per week as compared to pre-pandemic (Yamada *et al.*, 2020). In Ireland, it is reported that over one fifth of older people (22%) did not meet the required minimum physical activity recommendations since the outbreak of the pandemic (DeLooze &

McDowell, 2021). Similarly, an online survey of older people in Asia, Africa, Europe and other regions (n=1047) demonstrated a reduction in physical activity intensity and an increase in daily sitting times (from 5 to 8 hours). Older people with lower physical activity are reported to have higher stress, anxiety and depression levels pointing to the need to target physical activity both now and post pandemic (Gerritsen & Oude Voshaar, 2020; Ward *et al.*, 2021). Moreover, social connections foster physical activity which in turn optimises health (Pérez *et al.*, 2021). Consequently, the restrictions on social connections, as discussed previously, could reduce physical activity, quality of life leading to adverse health outcomes such as hypertension, pain, fatigue and cardiovascular disease (Van Orden *et al.*, 2020).

Physical health may also be impacted by a reduction in appetite, as the desirable social interaction while eating contributes to the occasion and enjoyment of food (Kuwahara *et al.*, 2020; HSE, 2020). Healthy food choices have also reduced in pandemic times with an increase in snacks, food types and a lack of control of food consumption (Ammar *et al.*, 2020). COVID-19 has highlighted the need to supplement daily nutritional intake with vitamin D which contributes to positive mental health, bone health, calcium absorption, muscle strength, but more specifically for COVID-19, can bolster the immune system (Laird & Kenny, 2020). With a reduced opportunity to go outside, an inadequate dietary intake, limited sunshine and deficits in vitamin D levels (Lim *et al.*, 2020; Laird & Kenny, 2020), there has been government recommendations for all adults to supplement their diet with 20-25µg/day, with higher doses for at risk people under medical supervision (Department of Health, 2020; Houses of the Oireachtas, 2021).

Physical health may be impacted by shielding in the context of lessened physical functioning, worsening health conditions or new health issues, such as the consequences of falls (Peliconi & Lord, 2020; Levkovich *et al.*, 2021). Bailey *et al.* (2021) found 40 percent (59/150) of older Irish respondents expressed a decline in their physical health in the context of poorer mobility and diet, disturbed sleep, and low energy levels, with one third indicating they had not left their house. In addition, 42 percent reported exercising less, which is slightly lower than other studies (i.e. Suzuki *et al.*, 2020). Similar findings related to a lessening of both function and cognitive capacity are identified in the UK, where two in three older people reported having less energy, while there was an increase in general mobility challenges and cognitive

functioning (Age UK, 2020). The decline in the physical health of older people may lead to higher levels of frailty and sarcopenia as well as emotional and mental health challenges. Moreover, such decline is likely to impede the older person's return to pre COVID-19 health levels, particularly if help-seeking from professionals is delayed or community services suspended or reduced (HSE, 2020; Kuwahara *et al.*, 2020; Davis *et al.* 2020; Chen, 2020; DeBiase *et al.*, 2020; Pérez *et al.* 2021). Ward *et al.* (2021) details the physical activity of older Irish people recruited from the TILDA study. With a 66 percent response rate, they found that 47 percent reported about the same amount of exercise than before the pandemic with 16 percent indicating decreased exercise levels while 17 percent reported an increase. In terms of walking, one quarter reported engaging in this activity this less often, while 27 percent reported walking more. However, undertaking activities such as home DIY or gardening increased by 45 percent (Ward *et al.*, 2021).

Services

The United Nations (2020) identify that public health measures can significantly impact access to health services, consequently delaying diagnosis, and treatment. Access to services has been a challenge for older people during the pandemic (UN, 2020a; HSE, 2020) with one study indicating that 20 percent found it difficult to access health services (AARP, 2020), while other studies report limitations on services such as access to mental health care (Flint *et al.*, 2020; Gorenko *et al.*, 2021) or dementia care (Cohen *et al.*, 2020). Like other countries (Flint *et al.*, 2020; Rais *et al.*, 2020; Lim *et al.*, 2020), the provision of community services in Ireland was somewhat restricted following the pandemic declaration. For example, home care services to 11,300 community dwelling people were put on hold, while day care provision was suspended (Pentaris *et al.*, 2020). As these important community supports ceased, it is likely that in addition to other consequences, the sense of loneliness and social isolation was exacerbated due to reduction in face-to-face contact. Being socially isolated has been associated with unmet need related to seeking practical assistance with hygiene needs, meals and transport (Kotwal *et al.*, 2021), which can be intensified if cognitive impairment is present (Portacolone *et al.*, 2021). Thus, disruption in the receipt of services could also lead to a worsening of health status (Graham, 2020).

Exclusion from services, whether self-exclusion (Heid *et al.*, 2021) or institutional exclusion (cancelling of service) can impact pandemic response efficacy (Wong & Kohler, 2020). This particularly applies in a direct way in a reluctance to seek help for the diversity of manifestations of COVID-19 related symptoms or indirectly in a reluctance or inability to seek or source services for other health issues. Ward *et al.*, (2021) demonstrated that almost one third of older people delayed medical treatment in Ireland since the onset of the pandemic. Reasons given were personal choice, cancellation by the medical facility or not being able to avail of an appointment (Ward *et al.*, 2021). ALONE reported calls where older people had put off attending hospitals for medical treatment or examination, while over half were not supportive of virtual clinics (Bailey *et al.*, 2021), although it is recognised that evidence-based wellness programmes can help to prevent falls, promote mental health and help to assist in chronic illness self-management (Smith *et al.*, 2020). A recommendation has been to positively discriminate in favour of older people with complex health problems and prioritise healthcare services to be delivered in their homes (Petretto & Pillo, 2020; Roy *et al.*, 2020; D’Cruz & Banerjee, 2020). Priority should also be given to older people with emergency health issues, such as delirium, falls and end of life care for older people living with frailty (Lim *et al.*, 2020).

Safeguarding

Safeguarding may be defined as:

“Putting measures in place to reduce the risk of harm[abuse], promote and protect people’s human rights and their health and wellbeing, and empowering people to protect themselves”

(Mazars *et al.*, 2020:28).

There are multiple forms of abuse types which include physical abuse, emotional/psychological abuse, financial/material abuse, organisational abuse, neglect, discriminatory abuse, online, digital abuse, human trafficking or modern slavery, abuse as an infringement of rights, social abuse, peer to peer abuse and medicinal or chemical abuse (Mazars *et al.*, 2020). COVID-19 has been identified as an aggravating factor in increased calls to abuse helplines (Elman *et al.*, 2020) and incidents of abuse perpetration (Boserup *et al.*, 2020). Such calls may represent a new case of abuse or an intensification of existing abuse (Makaroun *et al.*, 2020). For example, Women’s Aid reported a 43 percent increase in helpline calls between the end of March and the end of June, compared to 2019 figures with a

concurrent 71 percent increase in visits to their webpage (Women's Aid, 2020). Such increases have resulted in intimate partner violence being termed "a pandemic within a pandemic" (Evans *et al.*, 2020: 2302). Safeguarding is closely connected to the human rights' principles of autonomy, self-determination, and liberty, while ageism is associated with elder abuse (Phelan & Ayalon, 2020). It has been argued that public health measures have impacted the human rights of older people and is exacerbated by little, or no older voices being elicited regarding their views on the public health restrictions in COVID-19 response (Peisah *et al.*, 2020; Mahler, 2020; Mills 2021).

The Health Service Executive (2014) defines elder abuse as:

"...any act, or failure to act, which results in a breach of a vulnerable person's human rights, civil liberties, physical and mental integrity, dignity or general well-being, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative. Abuse may take a variety of forms"

(HSE Social Care Division, 2014:8).

Global estimates demonstrate that one in six older people experience abuse (WHO, 2020b) and prevalence is much higher for older people living with dementia (Cooper & Livingston, 2020). An Irish study (n=2021) indicated a prevalence of 2.2 percent, with financial abuse being the most common form of abuse (Naughton *et al.*, 2010). In most cases, perpetrators were known to the older person (relative/friend) and risk factors were identified as him/her living with the older person, being unemployed or a history of alcohol abuse. Risk factors for the victim included being female, being in the older old age groups, having lower income and lower education, poor health and poor levels of community or family support (Naughton *et al.*, 2010). Although data on elder abuse is currently limited relating to the pandemic period, both the WHO (2020b) and the United Nations (2020b) recognise the potential for increased incidences in the pandemic while public health measures have exacerbated risk factors (Storey, 2020).

In Ireland, family support of older people is common, with 70 percent of those who have functional limitations and require support, receiving this from their family (McGarrigle & Kenny, 2020). Increased caregiving roles, in the context of shielding and service limitations, may intensify carer stress, which may be compounded by longer hours, working from home and concurrent childcare responsibilities (Lim *et al.*, 2020; Rais *et al.*, 2020; Elman *et al.*,

2020). When reviewing the general risk factors for elder abuse, the context of COVID-19 overlaps with, for example, caregiver stress, dependency, psychological problems, poor social support, cognitive impairment poor health and frailty (Johannesen & LoGiudice, 2013; Pillemer *et al.* 2016; Rina *et al.*, 2020). Rina *et al.* (2020) posits strained personal relationships, financial stress, anxiety about catching COVID-19 and difficulties in accessing services as triggers for elder abuse in the pandemic. Moreover, the imposition of social isolation as a public health measure translates to increased difficulty in accessing help and, if the perpetrator is the care provider, difficulties in disclosing due to a fear that it could impact on the ability to continue to live at home in the community. Self-neglect may also occur in pandemic situations as worry may obscure self-care activities (Banerjee *et al.*, 2020).

Of note, financial abuse is an issue in COVID-19 as older people have been targeted for scams (Moore & Hancock, 2020) with Age Action Ireland (Pollack, 2021) and the metropolitan police (2021) in the UK reporting coronavirus decontamination scams, while the US Federal Communications Commission (2021) has also warned about COVID-19 scam calls and texts. In addition, the economic impact of COVID-19 has been challenging, with many people on statutory support such as pandemic unemployment payments while predictions of a future recession, may further exacerbate the risk of financial abuse (Makaroun *at al.*, 2020) as younger generations struggle and seek to compensate fiscal losses. As substance misuse, a risk factor for elder abuse perpetration (Pillemer *et al.*, 2016) has risen in the pandemic (Zaami *et al.*, 2020; Abramsom, 2021), it may also translate to an increased risk of financial abuse and/or other abuse types.

The potential for increased elder abuse is borne out by a rise in reports of abuse (Han & Mosqueda, 2020). An on-line survey in the US (n=897) identified that older people during COVID-19 have experienced greater levels of physical (+237.5%), verbal (+0.02%) and financial abuse (+114.3%) (Han & Mosqueda, 2020). While such figures are concerning, the authors suggest that these are underestimations as the sample was comprised of healthy adults with digital literacy and access to the internet. In addition, the study did not include frauds and scams, which have been reported as targeting older people during the pandemic (Han & Mosqueda, 2020). While research has identified a strong sense of community and adherence to physical distancing as protective factors against abuse (Chang & Levy, 2021), other reports

have also suggested a tenfold increase in perpetrations (Sajan, 2020). Moreover, Elman *et al.* (2020) observe that for older people who were already in abusive situations, the pandemic could escalate the mistreatment, and detection may be more challenging due to little or no social contact beyond the perpetrator.

In the context of residential care of older people, a study gathering data from members of the International Network for the Prevention of Elder Abuse (INPEA) in 16 countries identified that 47.7 percent were aware of abuse of older people in nursing homes being reported through local media outlets during COVID-19 (Beaulieu *et al.*, 2020a, 2020b). When asked the types of abuse they suspected in residential care in the pandemic, all respondents suggested psychological abuse was likely to have occurred; 77.8 percent suspected neglect was likely, 44.4 percent suspected financial abuse as likely, 38.9 percent suspected physical abuse as likely and social abuse (refusing visits from families) was suspected as likely in 11.1 percent of the survey responses (Beaulieu *et al.*, 2020a, 2020b). Participants also commented on the diverse levels of care quality, with some indicating that staff had no training in care delivery or infection control (Beaulieu *et al.*, 2020a). Lowenstein (2020:89) comments that while public health measures mandated social isolation, for older people in nursing homes, this could constitute “fatal isolation.” In addition, the lack of visiting could remove a mode of surveillance, for example by relatives or regulatory bodies, which Gardner *et al.* (2020) suggests increases the risk of unfettered abuse.

Safeguarding Ireland (2020) report that 12 percent of adults have experienced abuse and neglect during the pandemic, with cyber abuse becoming more prominent. Although it is recommended that formal responses to suspected abuse cases are instigated as soon as possible (Elman *et al.*, 2020), in Ireland, efforts to combat the pandemic have led to safeguarding staff being redeployed to contact tracing (Brennan *et al.*, 2020). This has exacerbated prolonged responses to safeguarding concerns due to understaffing with a reported backlog of 1,812 referrals as well as 1,629 unreviewed safeguarding plans (Reilly, 2021). This delay is most severe in Community Healthcare Organisation 7 (Dublin South, Kildare and West Wicklow).

Intervention strategies relating to older adults during COVID-19

While there has been progressive iteration of intervention strategies in relation to managing the COVID-19 pandemic, this section explores such interventions in relation to the older population. These include interventions at the micro-level of the individual person such as countering the unintended consequences of public health restrictions, promoting positive health, delivering services in alternative ways, carer support and managing public health information. At the meso-level, social capital approaches have mobilised communities to support older people. While the public health responses to COVID-19 represent a macro-national approach and have been discussed earlier, a substantial population level response has been the roll out of vaccinations to provide immunity.

Micro-level

While older people know of the need to socially isolate, they may not be as aware of the need to maintain social connections (Smith *et al.*, 2020) and having good social connections has been demonstrated to counteract stress (McDonald & Hülür, 2021). Being mindful of low mood and where to source assistance is central to wellness (Tappenden & Tomar, 2020). However, older people often do not have the same resources as younger generations, in terms of material resources (technology, social, family and friends) or some may have cognitive or physical challenges which limits active participation (Vahia *et al.*, 2020). Keeping in contact with family and friends is crucial and using the social capital within the community can compensate for limitations in family/friend related human connection or instrumental activities of daily living (community groups, NGOs, telephone support lines/groups).

Other focus areas within the context of interventions are the use of activities (reading, puzzles, memory games) to sustain cognitive function and provide occupation. Older people should maintain some physical activity to retain function and counteract poor mental health. As discussed earlier, depression can impact poor appetite while poor appetite can increase risk of depression (Kimura *et al.*, 2020) thus, ensuring good nutritional habits is key (Radwan *et al.*, 2021). COVID-19 infection can impact nutritional intake, with a loss of taste, smell and swallow reflex; in the severe phases, tube feeding may be required (HSE, 2020). It is also advised that older people keep a regular sleep-wake habit (Lim *et al.*, 2020; Sepúlveda-

Loyola *et al.*, 2020). Keeping a daily and weekly routine is similarly important with daily goals identified (Tappenden & Tomar, 2020). In addition, for older people who have spiritual and religious connections which give solace, being able to maintain these practices through alternative mediums (i.e. internet/television) can sustain them in the absence of attending in-person services (Makridis *et al.*, 2020).

Regarding maximising physical health, a preventative focus incorporates many actions (Sepúlveda-Loyola *et al.*, 2020) such as reducing sedentary behaviour, promoting relaxation techniques and engaging in aerobic, strength, co-ordination, balance and stretch exercises. These could be supported through online classes, targeted television programmes, hard copy information with illustrations and both family and professional encouragement and support. For example, in Singapore, bespoke online exercise programmes and dementia programmes were developed to compensate for physical and cognitive deconditioning (Rais *et al.*, 2020). Older people can also be encouraged to mobilise outside with caution and utilise times where parks etc. are less busy.

Health services have attempted to compensate for the lack of face-to-face interaction through mediums such as teleconferencing (Frawley *et al.*, 2020; Yi *et al.*, 2020), and remote monitoring (Aalam *et al.*, 2021) with plans to maintain these service modes post-pandemic (Richardson *et al.*, 2020). While many health consultations have transferred to telephone or virtual methods (Yi *et al.*, 2020; Lalor *et al.*, 2021), the digital divide within younger and older age groups has been observed, with the United Nations (2020a) and Age UK (2020) identifying this as exacerbating poor access to services and communication limitations in COVID-19. This divide has many influencing factors but Kotwal *et al.*, (2021) highlight poor access to technology and being uncomfortable with its use as key barriers suggesting utilising mediums such as television as this is more widely accessible for older people (Lim *et al.*, 2020; Petretto & Pili, 2020; Rais *et al.*, 2020).

Gorenko *et al.* (2021) point to the need to provide suitable interventions to counter negative impacts on older people's wellbeing which underpins bonding within social capital. The authors conducted a narrative review on potential interventions and suggest an alignment with older people's preferences of the type of non-face-to-face communication and a

consideration of barriers to using technology. In addition, privacy in health conversations and adapting care delivery to remote mediums is recommended. The importance of using digital communication is crucial in maintaining social connections and promoting social capital (Pitas & Ehmer, 2020; Peliconi & Lord, 2020; Smith *et al.*, 2020; Kotwal *et al.*, 2021) and virtual connections can reduce the impact of social isolation (Kimura *et al.* 2020; Hamm *et al.*, 2020; Siette *et al.*, 2021). This encompasses not only using the telephone to provide interventions but, if the older person is agreeable, to maximise existing familiarity with technology, providing support to use technology over the phone, using print materials to guide developing competencies and involving a live-in family member/other to assist in navigating technology.

It is recognised that virtual communication is not sufficient to combat social isolation (No Isolation, 2018) as it is not as advantageous as in-person communication and lacks an aspect of closeness and intimacy (Claridge, 2020; Heid *et al.*, 2021). Equally, its uptake during the pandemic may be low for community dwelling older people as many do not have smartphones or internet services (Makaroun *et al.*, 2020; Smith *et al.* 2020). Also, older people's connectivity using internet modes is globally diverse with one study identifying three quarters of older participants having minimal or no internet based social interaction (Kotwal *et al.*, 2021), while an Australian study identified that over 90 percent of older people used technology to keep in touch with friends and family (Siette *et al.*, 2021). In the UK in 2020, 54 percent of those over 75 years had recently used the internet (Office for National Statistics, 2021). Irish figures demonstrate that 59 percent of those between 60 to 74 years accessed the internet daily, while 28 percent of those aged 75 years and over accessed the internet every day with email being the most popular activity for all age groups (CSO, 2020).

For older people experiencing loneliness and social isolation, there is a lack of knowledge on the efficacy of interventions used in the pandemic (Smith *et al.*, 2020; National Academy of Sciences, 2020; Peliconi & Lord, 2020). This points to additional research on areas such as social prescribing (which is available in many counties in Ireland), the acceptance of and wider internet use by older people as well as other in person and remote ways to address loneliness and social isolation. It has also been highlighted that there will be a need to focus specifically on older people post-pandemic. For example, Kimura *et al.*, (2020) emphasise the need to ensure older people, especially those living alone, have (re)connections with social contacts,

encouraging the practice of social participation and for social activities to recommence such as family or friends joining older people for meals. Given the potential for physical deconditioning and psychological and mental health deterioration, a robust multi-domain rehabilitation plan is key to health optimisation.

Roy *et al.*, (2020) predicts that COVID-19 will not be the last pandemic. Thus, learning from older people's experiences and related impacts of and recovery from shielding will bolster future preparedness and identify ways to maximise resilience. In the post COVID-19 world, extensive emphasis will be needed to complete comprehensive geriatric assessments and to address rehabilitation of older people in the context of any mental and physical health deterioration. A key focus should be on increasing resilience with inclusive access to multi-disciplinary services, including community intervention teams, which address deconditioning and maximise recovery (DeBiase *et al.*, 2020; Webb, 2021; Pérez *et al.*, 2021). Importantly, Lim *et al.* (2020) also points to the need for continued access to emergency services, pharmacy and food supply chains, with free delivery. The use of non-pharmacological therapies, such as cognitive behavioural therapy, spirituality etc., is important to address anxiety, stress and other challenges to psychological health (Vahia *et al.*, 2020). A controlled opening of social, religious and medical health services (day care) should be considered (HSE, 2020), particular as vaccinations programmes roll out.

Studies have shown there can be mental health issues and impaired quality of life one year after an epidemic (Jalloh *et al.*, 2018; Lee *et al.*, 2007). For successful recovery plans for individual older people, it will be necessary to take a holistic, person-centred approach in reviewing physical function, social connectivity and mental health while also considering how to support carers (Pérez *et al.*, 2021; Petretto & Pillo, 2020; Rais *et al.*, 2020). In addition, the National Treatment Purchase Fund does not identify waiting lists by age. It is anticipated that these lists have increased during the pandemic, therefore overt efforts to identify and prioritise older people's care (assessment, diagnosis and treatment) are needed (HSE, 2020). In the context of long COVID-19, NICE (2020) identifies self-management and supported self-management, which includes service provision and advice about financial support, multi-disciplinary assessment, and symptom management. For older people, it is recommended

that short term care packages, advanced care planning and supports with experiences of loneliness and social isolation are available (NICE, 2020).

Carers are important supports for older people, particularly for those older people living with cognitive difficulties such as dementia. In a study undertaken in the US, 5,412 respondents completed an online survey with 66 percent of carers reporting at least one mental or behavioural health symptom related to caregiving in the pandemic (Czeisler *et al.*, 2020). Consequently, carers need support as the hours of caregiving may have increased, with lowered state assistance. In a study by Family Carers Ireland (2020), carers were found to worry about contracting the virus and not being able to provide care if this happened. They also worried about their own and the care recipient's health, access to services, and financial issues. Carers or other family members may adhere to stricter than required rules (if outside the risk groups) by engaging in shielding to protect the older person, thus, ensuring their physical and mental health is supported is also a key consideration.

Finally, as fake information is associated with higher psychological stress (Lim *et al.*, 2020; Radwan *et al.*, 2021), media regulation is needed to ensure authentic information from official sources, with clear messages supported by an older person reference group. This translates to reducing the consumption of misinformation, while avoiding excess consumption (Sepúlveda-Loyola *et al.*, 2020; HSE, 2020) which could lead to catastrophising. Information also needs to be focused, unambiguous and presented in an understandable way.

Meso-level-Social Capital

Ireland, like elsewhere has evidenced the role of social capital in the COVID-19 epidemic. Social capital may be described as social context that has productive benefits which includes solidarity or goodwill between people and groups of people as well as an individual's exercise of social responsibility and concern for others (Claridge, 2004). This incorporates the formal and informal norms in society and civic duty. Various forms of social capital include the social environment, response support within trust (in others and in political institutions), norms (supports, assistances and collective efficacy) and networks (group membership which may result in benefits for individuals/groups) (Makridis & Wu, 2021). Within COVID-19, bonding capital, which represents the networks within friends and family and is a subset of social

capital, has been disrupted. This is also aligned with cognitive social capital, a subjective self-evaluation of social connectiveness, which was also impacted in older people adhering to shielding advice. Conversely, bridging capital, which is aligned with structural capital (a second subset, with objective external involvements or denoting social networks between heterogeneous groups) has increased, for example through volunteerism within communities who have demonstrated intergenerational solidarity to support older people (Putnam, 2000; Sun & Lu, 2020).

Studies have demonstrated social capital's relevance to pandemic times and importantly, its relationship with extending support to risk populations, social resilience and recovery (WHO, 2005; Pitas & Ehmer, 2020; Sun & Lu, 2020; Wong & Kohler, 2020; Makridis & Wu, 2021; Wu *et al.*, 2021). For instance, areas with high social capital demonstrate greater compliance with public health measures (Borgonovi & Andrieu 2020; Ding *et al.*, 2020), testing (Wu *et al.*, 2020), fewer cases (Sieglock, 2020) and vaccination acceptance (Chuang *et al.*, 2015). Social capital is evidenced by organisations and networks which cooperate for mutual benefit (Putnam, 1993) with high levels of trust and reciprocity supporting positive health (Sun & Lu, 2020). Responding to the crisis requires individuals, communities and governments ensure positive social ties within communities (Pitas & Elmher, 2020), while trust in government has been shown to have the strongest impact in reducing individual risk of COVID-19 (Wu *et al.*, 2020).

Despite the challenges identified in government responses to safeguarding older people during the pandemic (Lloyd Sherlock *et al.*, 2020), there has been a mobilisation of community support. For example, in Italy older people's civic action of volunteering to assist in pandemic responses has been evidenced with suggestions that they may assist the effort by continuing care delivery for grandchildren whose parents are essential workers (Petretto & Pili, 2020). Other instances include people signing up to 'Ireland's Call' and the multiple instances of community mobilisation (HSE, 2020) and support for older people such as the work of ALONE, the Gardai Siochana, An Post, Age Action and local Gaelic Athletic Associations, which have been important aspects of support in the context of individual, community, and national social capital responses.

There are complex factors at play in the context of social justice, rights, and autonomy at an individual and policy level for older people during COVID-19 (Brennan *et al.*, 2020). Ageism is related to the relative invisibility of older people and rights violations have been evidenced in the lack of reporting of the scale of older person deaths, particularly in relation to residential care (Beaulieu *et al.*, 2020a). The lack of appropriate attention in some countries to the volume of COVID-19 deaths of older people has been criticized as “moral decay” by the WHO Director-General Tedros Adhanom Ghebreyesus (Editorial, 2021), demonstrating an unequal value on human life based on age. In addition, Petretto & Pili (2020) point to the potential for ageist healthcare practices when resources are limited, and younger people are favoured for treatment (Popescu & Marcoci, 2020). Using ethical frameworks, inclusive language, valuing older people’s ability to contribute and avoiding a discourse of risk are essential to combat ageist assumptions and increase resilience (Lim *et al.*, 2020; Webb, 2021, Sepúlveda-Loyola *et al.*, 2020). The blanket approach in public health guidelines related to shielding mitigates against older people’s ability, if they wish, to engage in volunteering. Contributing to community efforts to address COVID-19 can be important to older people, particularly those in the young old group, and promotes solidarity as well as cognitive and structural social capital (Sun & Lu, 2020).

Macro-interventions: Vaccines

General policy on public health interventions at a population level has been discussed earlier in this chapter. Here, we consider vaccination programmes against COVID-19 as a significant intervention to protect people. Vaccinations have been the most effective weapon to eradicate infectious diseases and are available for over twenty diseases, such as measles, polio, mumps, rubella, influenza, and diphtheria (WHO, 2020). Several types have been produced related to COVID-19:

- mRNA vaccines which contain material from the virus that causes COVID-19.
- Protein subunit vaccines include harmless pieces (proteins) of the virus that cause COVID-19 instead of the entire germ.
- Vector vaccines contain a weakened version of a live virus—a different virus than the one that causes COVID-19—that has genetic material from the virus that causes COVID-19 inserted in it (this is called a viral vector).

(CDC, 2021b)

There are multiple vaccines approved or in trial to combat COVID 19 (see appendix 1). While the initial roll out of the vaccination programmes supported retaining the same vaccine for

second doses, more recent research has pointed to the benefits of combining different COVID 19 vaccines (Calaway, 2021).

It has been recommended that older people engage in some aerobic exercise in the weeks leading up to vaccination with campaigns highlighting the positive benefits of exercise with encouragement to continue post vaccination (DeLooze *et al.*, 2021). It is important to remember that full immunity only occurs two weeks after the full completion of the vaccination schedule. There has also been different recommendations applied in terms of age groups and people receiving the vaccination should be made aware of side effects such as fatigue, headache, and chills. The vaccines do provide protection against Covid-19 “variants of concern” (B.1.345, B.1.1.7, B.167.2, P.1); however, their efficacy is reduced (Katella, 2021). This is because such variants mutate and have the potential to reinfect people who have been previously infected with COVID-19 or those who have been vaccinated. In addition, variants of concern can be more transmissible, particularly in unvaccinated people, and have higher severity impacts on individuals (Michie *et al.*, 2021).

There is a lack of clarity around the length of time immunity is conferred for (HPRA, 2021) with emerging evidence to support a minimum of six months immunity (Pfizer Biontech, 2021; Doria Rose *et al.*, 2021) with further reviews on the need for booster doses (Miller, 2021; Callaway, 2021). From mid-2021, some countries such as Israel, Hungary and others have either commenced a booster dose or have announced a plan to administer third doses (Furlong & Deutsch, 2021). Some concerns have been raised about the safety and efficacy of some vaccines in different age groups and related to side effects such as blood clots with some countries suspending use or limiting use. However, EU and UK regulators do not support an age limitation while the European Medicines Agency (2021) indicates the benefits outweigh the risk of vaccination.

Vaccination roll-out in Ireland commenced on 29th December 2020, with priority given to older people in nursing homes, health care staff and the vaccination programme progressed to people medically at-risk and then the general population. The CSO (2021d) reported that 5.4 percent of people will not accept the vaccine, with 66.2 percent concerned about their long-term side effects. However, while the flu vaccination between 2016-2019 had a 59

percent uptake, the uptake of the COVID-19 vaccination has been much higher with the Minister for Health, Stephen Donnelly (2021a) reporting on the 11th March 2021 that 99 percent of those over 85 years had been vaccinated. On August 25th, 2021, it was reported that, in Ireland, 100 percent of those aged 70 and over were vaccinated. Just over ninety eight percent of those aged between 60-69 years were vaccinated with a total population vaccination rate of 85.5 percent (full dose) (EDCD, 2021).

SUMMARY OF BACKGROUND AND CONTEXT LITERATURE

- COVID-19 has presented a major challenge in global health, social and economic systems.
- Older people have been disproportionately impacted in terms of morbidity and mortality rates.
- Public health responses have focused on trying to minimise the spread and impact of COVID-19 and measures such as social distancing, the wearing of masks and limits on socialisation have impacted the whole population.
- Older people and those who are described as medically at risk have been advised to shield during the COVID-19 pandemic, with support bubbles encouraged in the latter part of 2020.
- The literature related to older people's experience of the pandemic illustrates the impacts on the social, psychological, mental, and physical health and well-being of older people as well as access to services.
- Findings from the literature point to negative experiences which can be affected by issues such as shielding, perceived loneliness, support available and duration.
- Some countries, including Ireland, have attempted to address service access via telephone and virtual clinics, although, this form of outreach was not reported by the older people in this study.
- Enabling social capital has also been a major support for older Irish people and has been noted as important in other countries' responses.
- While commentators and incidence indicators, such as helplines, have pointed to issues related to human rights and safeguarding for all ages, little empirical research has been undertaken to date on this topic in the context of community dwelling older people's experience of abuse during the pandemic. To date, research focusing on COVID-19's impact on older people undertaken in Ireland has generally used a survey-based methodology and/or consultation approaches and has demonstrated both coping mechanisms and negative impacts on health, social connections and access to services.

- In contrast, this study has enabled an understanding of older adults' perspectives using a qualitative lens, enabling the nuances of experiences to be further explored.
- The following chapters will overview the research methodology and methods employed during the study (Chapter 2), present the findings of the study (Chapter 3), discuss the findings in the context of the available literature (Chapter 4) and finally present the conclusions of the study (Chapter 5).

CHAPTER 2 METHODOLOGY

STUDY AIM

The aim of this study was to identify older people's experiences of shielding during the COVID-19 pandemic.

STUDY OBJECTIVES

- i. To explore older people's experiences of shielding as a public health measure.
- ii. To identify the personal circumstances of shielding (i.e. alone/family).
- iii. To identify facilitators and challenges within the period of shielding.
- iv. To elicit any consequences of shielding (physical/psychological/social).
- v. To consider any lessons which are important considerations if shielding of older people is necessary as a future public health measure.

STUDY DESIGN

A qualitative descriptive design was chosen to underpin the conduct of the study as this research approach enables an inductive understanding of the experiences of older people. It is a research design that is particularly suitable to the identification of the who, what and where of experiences and is particularly apt in research where the phenomenon being studied is new or little understood (Kim *et al.*, 2016). This research design was also chosen due to its inherent "simplicity, flexibility and utility" and its suitability for research that aims to stay close to the experiences of participants (Doyle *et al.*, 2020).

ETHICS

Ethical permission to complete the study was granted by the Faculty of Health Sciences' Research Ethics Committee in Trinity College Dublin (TCD). The ethics application was also subject to a Data Protection Impact Assessment by the Data Protection Officer in TCD. Each participant received a participant information sheet and a copy of the consent form, and a seven-day period was provided to enable potential participants to review the information and

make an informed and voluntary decision to participate. All ethics requirements were complied with including the General Data Protection Regulations (2018). At all times the welfare of participants was placed above the interests of the study and a process approach to ensure ongoing consent was employed during each interview. In addition, a protocol was agreed within the research team to ensure the welfare of a participant should an individual become upset during an interview. This protocol did not require enactment. However, the participant information leaflet also contained information on relevant support services in the case that a participant wished to avail of such support.

SAMPLE RECRUITMENT

Support for access to conduct the study was given by the Director of Public Health Nursing in one Community Health Organisation based in the East of Ireland. The researchers provided a study information leaflet to public health nurses (PHN) and registered community general nurses (CRGN) that described the study and requested they act in the role of gatekeeper in relation to distributing information packs to older people who met the study inclusion criteria. PHNs and CRGNs in Ireland work within a geographical caseload basis. Each caseload represents a diverse age representation, which is commonly described as ‘cradle to the grave’ (Irish Nurses and Midwives Organisation, 2013). Three PHNs/CRGNs agreed to distribute the information packs to recruit a convenience sample of 20 older people. The information packs for older people contained a) a participant information leaflet which requested any interested potential participant to contact the principal investigator to discuss the project and ask any questions, and b) a copy of the consent form for review. A period of one week was facilitated for the older person to decide if they wished to proceed. In total, 20 people agreed to participate in the study; two participants were included although they did not reach the age of 70 years. However, they were medically at risk or shielding to support a spouse who was at risk and were subject to the same public health measures as those in focus in the study.

INCLUSION CRITERIA

Participants were selected to participate in the study if they were a community dwelling older person who:

- 1) had shielded-regardless of living alone or not.

- 2) demonstrated decision-making capacity using a functional approach.
- 3) was aged 70 years or over.

EXCLUSION CRITERIA

Potential participants were unable to participate in the study if they were an older person who:

- 1) did not reside in the community during the public health advice on shielding during the COVID-19 pandemic.
- 2) had no experience of shielding.
- 5) did not wish to voluntarily participate.

DATA COLLECTION

Data were collected between the period 14th January to March 8th, 2021. Three researchers conducted individual semi-structured telephone interviews with participants. Each interview was preceded by a formal documentation of explicit consent by the interviewer and clarification of any questions related to the study was again facilitated. Based on the aim of the study, a review of guidelines and emerging discourses on public health advice related to older people in the community setting during COVID-19, a bespoke interview schedule was developed. Interviews were recorded with participant permission and audio records allocated a numerical value matched to the older person, which was stored in a master key code file separate from the interview transcript. A total of 20 interviews were conducted ranging between 15 to 52 minutes. Participants included 8 males and 12 females ranging in age from 59 years to 92 years.

Audio recordings of interviews were securely transferred to a professional transcription service, which held a confidentiality contract with the School of Nursing & Midwifery, TCD. Once transcribed, transcripts were returned to the Principal Investigator. Transcripts were checked for accuracy against the audio recordings and the recordings were then destroyed by the transcription service and by the researchers. Transcripts were then reviewed to remove any identifying details (names, places etc) and then imported into a password protected folder on a secure research drive for analysis with access restricted to members of

the research team. As some participants requested key findings of the study to be posted to them, master key codes were then destroyed so that it was no longer possible to link a participant to an individual transcript but contact addresses were still available to forward the findings.

DATA ANALYSIS

Data analysis was undertaken using the thematic analysis approach described by Braun and Clarke (2006, 2012). This approach facilitates the uncovering of patterned meaning across a qualitative dataset to address the research purpose (Terry *et al.*, 2017; Braun and Clarke 2012). According to Clark and Braun (2018:108), employing this approach to analysis, thematic findings are “*active creations* of the researcher (rather than just passively ‘emerging’ fully formed from the data) that unite data that at first sight might appear disparate, and often capture implicit meaning beneath the data surface”. These writers further explain that in using this approach, each theme has an identified essence that both underpins and brings together its content in the process of interpreting the data. As such, a rich analysis of participants’ data can be achieved in terms of describing the so what of the data (Clark and Braun, 2018). All three members of the research team analysed the interviews in the current study using the six-stage iterative thematic analytical process detailed in table 2 below.

Table 2: Approach to data analysis (Braun and Clarke, 2006)

Step	Process
1. <i>Familiarisation with the data</i>	Following transcription, full transcripts were reviewed for accuracy. Following this, a repeated reading of each transcript was undertaken to enable immersion in the data. Preliminary notes were recorded and cross checking with fieldnotes.
2. <i>Generating initial codes</i>	Building on step 1, initial codes were developed and collated.
3. <i>Searching for themes</i>	Codes were analysed to generate overarching themes. This involved a discrimination of the codes and a review of interconnections between codes themes and analytic levels.
4. <i>Reviewing the themes</i>	Themes were reviewed and refined at code level, theme level and whole data level for coherency and representation of the older person’s perspectives.
5. <i>Defining and naming themes</i>	In this step, the themes were reviewed for completeness in the context of fully illuminating the essence of the theme. This involved a horizontal review of the total ‘story’ the themes told, and a vertical consideration of the constituent sub-themes and a refining of theme titles.
6. <i>Producing the report</i>	Writing the report involved an authentic presentation of the finding of the data analysis, with a clear audit trail of the theme development and supporting data.

Data analysis resulted in two overarching themes (Chapter 3), which represented the shielding experiences of the community dwelling older people during the pandemic period March 2020-January 2021.

RIGOUR

General standards of rigour in qualitative research such as credibility, transferability, dependability, and confirmability were adhered to (Lincoln & Guba, 1986). Each transcript was initially reviewed by one of the three researchers, but regular team meetings served to facilitate the development of themes by the research team and constant cross checking of emergent themes occurred with the data. Both actions served to strengthen the trustworthiness of and fidelity to the research process and the interpretation of the research phenomenon that resulted.

SUMMARY OF METHODOLOGY

- This study employed a qualitative descriptive methodology to achieve the research purpose.
- Ethical and Data Protection Officer approvals were obtained and participant recruitment, the completion of explicit consent, collection and secure storage of data, and the prioritisation of the welfare of participants were all addressed in line with the principles of good research practice.
- In total, twenty interviews were held with participants who volunteered to be part of the study having received the study information.
- Semi-structured interviews were conducted by telephone using a purposely designed interview guide to enable participants to recount their experiences of shielding during the COVID-19 pandemic.
- An inductive thematic analysis approach was employed to analyse the interview data.
- The trustworthiness of the research was ensured via the research team's adherence to the research protocol, process, and to standards of rigour in qualitative research such as credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1996).
- The following chapter will present the thematic study findings.

Chapter 3 Findings

INTRODUCTION

The aim of this chapter is to present the findings from the thematic analysis. Overall, the findings demonstrate both the resilience and challenges older people experienced during the COVID-19 pandemic. Two overarching themes were identified:

- 1) Shielding experienced as a social disruption.
- 2) Coping with and countering social disruption.

The themes are described in detail with supporting excerpts from the transcripts where appropriate. Figure 2 presents a visual representation of the themes and their relationship with each other.

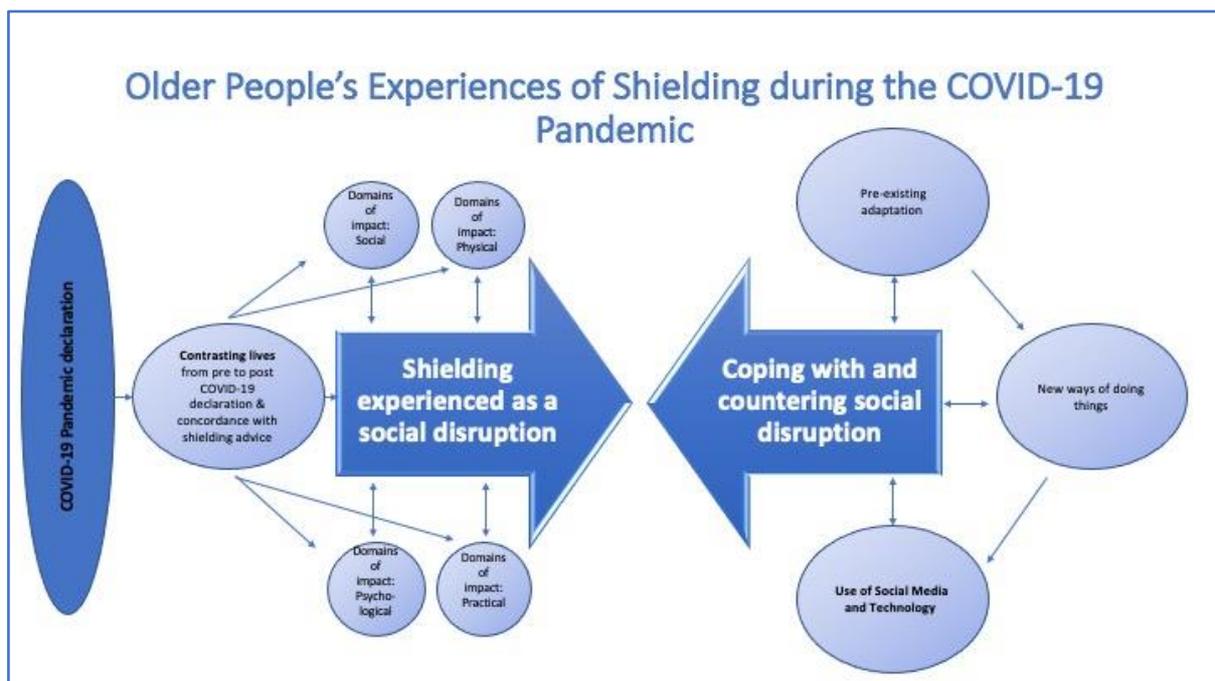


Figure 2: overview of themes and findings

THEME 1: SHIELDING EXPERIENCED AS A SOCIAL DISRUPTION

Shielding experienced as a social disruption, reflects the transformed lives of older people. As public health responses identified greater caution for those over seventy years and those considered medically at risk, enhanced advice was given by the Irish government regarding social restrictions. Compliance resulted in transformed lives with marked impacts on social

roles, identities, ways of living as well as the personal consequences of adhering to restrictions. The accounts from the older participants were imbued with careful strategies of self-protection and acute awareness of the personal and societal effects of the ongoing pandemic. However, such measures represented stark differences from pre COVID-19 life with impacts on social, physical, psychological, practical and spatial limitations. Shielding as a social experience is divided into three subthemes - contrasting lives, prioritising health and impacts of shielding. The impacts of shielding is further sub-divided into social, psychological and physical health consequences.

CONTRASTING LIVES

Many participants contextualised their experiences in terms of contrasts to their pre and post Covid-19 onset shielding lives following the declaration of the pandemic and national lockdowns, and in the light of their ongoing adherence to the shielding advice. To this end, there was extensive reference to shrunken spatial possibilities and impacts on the experience of time as components of the social disruption experienced. The shrunken spatial possibilities tended to be spoken about in two regards, those of geographic space and participants situated place as a family member, friend and citizen. For some participants, this led to significant changes to the experience of time, as the days' routines were undistinguished. All of these resulted in transformations due to impacts on the multiple life domains presented later in this first theme.

Connections with others during shielding, particularly those not in a participant's immediate defined social bubble, were not the same as pre COVID-19, so life-space had to be re-defined. This meant that the participants' evaluation of these redefined contexts, while recognised as the best that could be had in the circumstances, did not qualitatively reflect or equate with what had gone before. Life pre-COVID-19 as compared to the shielding experience, was referred to as taken for granted spaces, activities and interactions. Consequently, shielding experiences had led to participants making comparisons between what life was and what it had become:

Oh before this I would be out a few times a week. I would be out a few times a week, just whenever I felt like it, I have a car and I'd drive, I'm very independent like that. [Interview 4]

So I go out to the driveway where the car would normally be, we put it out on the road and just when the pandemic lifted or sorry when the lockdown lifted I would go down the footpath and that I miss a lot. Because I could go you know right down the road and I would be out for maybe twenty minutes down pass all my neighbours' houses and back again. And that was great but then when the lockdown comes, I stay inside the gate. [Interview 8]

When referring to redefined geographic life-spaces and their limiting impacts on the ways in which participants could engage in living and socialising, there was a sense of resignation and, for some, despondency:

But I do, I suppose I'd say it is the pandemic because if we didn't have that I'd have my friends and I'd have my partner... Yeah, and able to go out a little bit and that kind of, you know ... I used to meet up with my friends a lot and we'd go out for lunch. We'd go to concerts and plays and that kind of thing and I miss all that. [Interview 7]

Participants referred to the freedoms experienced pre-COVID-19. One dominant focus was being able to move about as they wished. The way this was expressed illustrated the centrality of geographic mobility in facilitating engagement in activities and interactions that influenced participants' sense of self and sense of purpose. This was contrasted with the COVID-19 and shielding related disruption to plans made for distant travel, for example, for holidays, to see family and attend events. Others referred to such disruption in terms of more localised geographic mobility that was central to everyday living and the pursuit of interests and activities of everyday living:

The one thing I couldn't go on any holidays that was one of the one things that kind of upset me because I always went on holidays every year and that was the one thing. And not being able to visit people you know or nobody coming in that was the only you know. [Interview 5]

With our daughter in law... so we used to see them we used to go to visit them, and we would also head for [Place] for a hotel holiday or similar we miss all that. [Interview 9]

But you know, to go that distance, well I can't, first of all I can't do the 5k, with the 5-kilometre thing but even if I could, I can't. [Interview 10]

These descriptions suggested a sense of confinement and ennui experienced post the declaration of the pandemic as the participants adhered to shielding advice:

I'm in the kitchen and I'm looking at four walls and when I get tired of those four walls, I go into the dining room and I look at a different four walls and then I go to the sitting room and I look at a different four walls again. [Interview 13]

As such, perceived impacts on free will and self-determination were expressed by all participants in that spontaneity, and the capacity for autonomous decision-making to follow social preferences, was curtailed. The decision to adhere to shielding advice was due to the fear of contracting COVID-19 and as the possibilities for and ability to move about fell within the remit of guidelines developed by those with responsibility for protecting public health, choices for activities outside the home became limited:

You just feel like you're locked in or hemmed in like, and you can't do anything. And I do wake up and I'll say now I'll do this today, I'll go up to the, I'll go down the post office, oh no I can't, here I am. You know you just feel like you're a prisoner, you know every time you think of something to do you have to knock it on the head because you can't do it, you know. [Interview 20]

Balanced with this, however, was a recognition of the need for the public health measures required to protect and ensure the safety and well-being of citizens:

But now it's [going out] all stopped so I mean we have to agree to the government regulations, that's all we can do, nothing else. [Interview 12]

But with the lockdown nobody is out, you know. And you just have to abide by rules if they want to try and get on top of it. [Interview 13]

The loss of the degree of control experienced post-COVID-19 was contrasted with the self-determination and freedom lived out prior to the pandemic and an ongoing tension between adhering to shielding advice and the desire to connect with a familiar wider geographic life-space:

... before the pandemic hit, prior to that, I was always out, I was never in... and I'm keeping myself within the five kilometres or whatever it is and even if I were visiting my grandsons, I couldn't because they're all living more than five kilometres. [Interview 1]

A number of participants described how shielding had heightened their awareness of time and its influence on their daily lives due to COVID-19 public health advice and their subsequent engagement in shielding. There were references to a loss of a sense of time due to the sameness of everyday living and the loss of anchor points during the day was linked to a loss of routines and days being experienced as lengthy:

And then it became very confusing unless you were watching the news to know what change had happened today. [Interview 14]

I just think the day... I mean I remember... I think I used to delay getting the dinner because then the evening wasn't so long like. The day can be very long when you don't have something to break it up. [Interview 16]

Time was also referred to by some participants in terms of their life-stage and the impact of shielding perceived as eroding the time they had left. Along with this, a number of participants described how their experiences brought awareness of their mortality and for some it was the first time they were confronted with a realisation of being older or being classified by others in this way:

But funnily enough, I've never actually felt old, you know, but I absolutely did then [when shielding]. You know, it sort of put you in a category, you're cocooning, you're over 70 and you know, stay in or whatever. And it's the first time I actually felt old so that was a bit depressing ... And my friends would feel that too, that suddenly this is the last few years you have and you're so restricted. [Interview 17]

It makes me mad that I can't, whatever time we have left I feel like I'd want to get in the car and drive wherever I want to drive. [Interview 19]

In summary, the findings here illustrate participants' experiences of contrasted lives from pre to post Covid-19 onset and concordance with shielding, and the accompanying sense of loss due to shrunken spatial possibilities and consequent impacts on the geographic life space within which life could now be lived.

Prioritising health

For many of those interviewed, a focus on health preservation was a priority during shielding and this was both a motivating factor to shield as well as an anticipated benefit. This focus was emphasised where either the participant or a loved one with whom they were shielding had pre-existing health conditions and the sense of being at particular risk was palpable in interview:

I have the carers come now when the lockdown came in March, I cancelled the carers and managed, my husband helped me we managed without them because I figured that it was better you know than taking any chances. [Interview 8]

I was just saying you can see the danger, you know, of the whole thing (COVID-19) under the circumstances. [Interview 10].

In this sense, shielding was understood as an act of self-care designed to mitigate risk. The importance of mask wearing, social distance and other public health advice was clearly understood and the threat to health from others was constantly at the forefront of participants' thinking. As such, the interviews could demonstrate a paradoxical internal inconsistency as the home could be viewed as a sanctuary of safety and at other times/simultaneously, as described previously, a restrictive space of confinement even if the motivation was to protect health:

Yes, I try to do everything they say about keeping safe. [Interview 3]

I go down the bottom of the road here, there's a post office and I get my pension, sometimes I leave it 2 weeks, but I wouldn't go out without a mask now ...And if anyone comes to the door, now my eldest daughter she's going to drop over some shopping to us and I put my mask on when she comes to the door, you know. [Interview 20]

Risk mitigation in the context of health was expressed in a different way by some participants for whom the prioritisation of health was referred to in terms of the fear that the participant might be a risk to others. This was particularly so where participants either had COVID-19, or symptoms that turned out not to be COVID-19 but resulted in fear of potential consequences. Where this occurred, one participant referred to withdrawing from already reduced social contacts even more, thus compounding spatial restrictions and related impacts. As such, in the study, the prioritisation of health was referred to in terms of the participant themselves, their partners in shielding and other social contacts.

IMPACTS OF SHIELDING

After the introduction of restrictions in March 2020, public health advice centred on limiting the spread of COVID-19, with enhanced guidance for the those over 70 years and those considered medically at risk. All participants in the study detailed measures they engaged in to comply with the advice and self-protected, but such measures had consequences on the older person's social, psychological, physical and spiritual lives.

Social lives

The dominant impact was within the social lives of older people which overlapped with psychological impacts. The limitations on remaining at home exacerbated a sense of social isolation and loneliness, particularly related to interactions with family and friends. The loss of comfortable and familiar socialisation habits was identified as being fundamentally different, being qualitatively poorer. Consequently, having reduced face-to-face contact exacerbated the sense of loneliness. When asked what impact this had on their lives, a common response was physical isolation. Older people reported compensating by using the telephone and virtual platforms, and while helpful, this did not deliver the same sense of connection:

Alright, sure I'm not going, I don't go out like you know, I haven't been out in ages, I think that's the worst part of covid, you know you can't see your friends or your family or anything you know. [Interview 20]

And whereas I obviously talk to her [friend] on the phone and sometimes if I'm walking the dog she'll come to the door and I'll talk to her from the wall, you know. But it's not the same, you know, it's not at all the same. [Interview 17]

Well, I think to be isolated. I know I'm talking to my friends on the phone but just the isolation. And my sons can't come into me, you know. [Interview 13]

While the use of the telephone and virtual platforms enabled a less desired medium of connection, the communication content was also impacted upon due to an alteration in the usual, comfortable flow of conversation. In addition, the loss of familiar communication rituals such as having a cup of tea with family and friends were also significantly missed. Thus, communication was considered uncomplicated when in person:

I can't talk to them [family] as I would if they were here, you know, I'm restricted with what I'd say to them. [Interview 3]

Many participants spoke of their experience of sadness with several citing the lack of face-to-face engagement with their grandchildren as being difficult. As time passed, there was a sense of missing important milestones in grandchildren's lives. Family celebrations were also impacted. For example, in the extract below, the participant reflects that adhering to public health measures meant a prohibition in meeting her first grandchild:

I had my first grandchild in November, but I can't see them. [Interview 15]

The sense of 'missing' denoted strong previous, positive relationships with children and grandchildren, which were both suspended and disrupted in the pandemic. This could cause upset:

Well no, it's the fact that you can't, like I haven't seen my grandchildren in months, you know, and I miss them. [Interview 13]

Yes, that's a problem [not seeing grandchildren]. That's a big problem. I suppose I've let it be, it's become a big problem for me. It's a very big problem for my wife and I'm very conscious of her being very upset about it, you know. And therefore, I'm upset. I feel I should be upset and I'd be saying that but I feel I should be upset. [Interview 1]

While missing physical interactions with grandchildren was challenging, this lack of 'in person engagement' could also impact on intergenerational solidarity, where grandparents assisted with child minding. This demonstrates important supportive roles within both normative and functional solidarity:

And we would normally, you know, for a couple of hours or maybe three or four hours some days take her [grandchild] as a bit of a diversion for ourselves to let [name of daughter] go out to do. ... Well, at best a break. [Interview 14]

In addition, if meetings occurred, there was a delicate balance of caution in these face-to-face connections with an acute awareness that even limited physical contact could be a source of infection:

And we're nervous then about visiting them [son and family] in case we pick up something and then the girls [grandchildren] can't come in to visit us, you know. [Interview 14]

In terms of previous social structure in these older people's individual lives, activities which were taken for granted were now missed. This could be socialising with friends where familiar and enjoyable routines of socialisation ceased:

We'd go out for coffee and I have a particular friend that lives quite near me and we might go to the [shopping] centre or we might go into town, and we just look around the shops and have a chat and you know, have a cup of coffee or have a bit of lunch. It's not that we'd be buying a lot or anything, and just come home. And that was kind of, it's just, it was nice, you know. [Interview 17]

Personal relationships also suffered with one older person noting that public health measures related to travel restrictions meant foregoing usual routines:

Yeah, and then my partner, he lives about 35 miles away. We can't see each other either... It is, it's very hard, very... because he would have been over here about at least three nights in the week and then, you know, during the week maybe we'd go out to lunch or something like that...So that like in that way, everything has changed for us. [Interview 7]

Psychological impact

The social restrictions of the pandemic related public health advice also had a consequence on psychological health (Brooks *et al.*, 2020; Cheung *et al.*, 2020). Impacts could range from anxiety to loneliness to more serious consequences where distress was described. These experiences revolved around the limitations due to shielding where social contact and usual social activities were restricted. The consequential psychological impact was, by far, the most common negative effect within the narratives of the participants. While the interrelatedness of social lives and loneliness is demonstrated in the previous section, this section will consider the psychological impact related to becoming infected, loved ones becoming infected, COVID-19 deaths and the burden of constant exposure to COVID-19 in conversations or via news' outlets.

Despite the negative impact of COVID-19 on participants' psychological health, resilience was also apparent. For example, one participant described a resolve to keep well and sustain a positive psychological perspective to avoid health deterioration and a potential admission to a nursing home, which was equated to giving up life:

I feel that if I hadn't fought, I would have ended up in a nursing home... Well I just wasn't prepared to give up on my life. [Interview 7]

Many participants described feeling both anxious and worried. Transformed lives were a consequence of public health advice that recommended shielding; however, this could be experienced as challenging and unacceptable. If a decision was made to venture outside, this was accompanied by a psychological response of anxiety related to becoming infected:

When we couldn't go out at all, I absolutely did. And I must say I was kind of quite anxious [catching COVID-19] about it then, you know, as well. [Interview 17]

The experience of anxiety also related to catching COVID-19 even when fully adhering to the public health advice. In the excerpt below, the older person details a fear of formal carers potentially precipitating cross infection:

But I think probably my biggest concern was that the other carer was quite young and you know, I was just anxious about how safe, how careful they were going to be. [Interview 16]

Older participants could also worry about others, for example, friends being infected.

But you just have to try and say to yourself and realise you have so much to be thankful for and kept hoping that you'd keep safe and that your friends also. [Interview 2]

Yes and then a few [friends] had to be tested but they, luckily they were negative. But it is a worry. [Interview 7]

As discussed in the previous section, the social impact of shielding restrictions translated to being physically isolated. This exacerbated the subjective experience of loneliness. When speaking of older people's experience in general, the participant below observes it as one of the major impacts of being confined to the home:

...loneliness is probably one of the biggest problems that they [older people] can't solve themselves because they're afraid to move out of the house in case they pick up anything. [Interview 14]

While many participants detailed their adherence to the public health advice, this was not without distress. When asked if the pandemic had caused any upset, in addition to worry and anxiety, there were manifestations of anguish such as crying due to the pandemic restrictions:

[asked if she is upset to the point of crying] Yes. Not all the time now, not all the time. [Interview 3]

Yeah, I'd be just, well I wouldn't show it to other people. When I'm here on my own, I'd have a few little tears. [Interview 7]

One participant had insight into her own behavioural changes, recognising that she became "very agitated" [Interview 14] due to the public health restrictions while another had needed formal psychological support:

I was a little down and have [had] HSE counselling, but that stopped now. [Interview 15]

Participants also observed changes in their friends. For example, in the next excerpt, the participant recalls the psychological impact on her friend which was accelerating from anxiety to a more serious mental health difficulty. This impact was sufficient to have her family suggest breaking the shielding advice to alleviate the distress:

And my friends down there... they both live on their own, they're all widows and she says to me yesterday evening, she was crying on the phone, she said I think I'm going to go mad she said, I can't, then her son rang me and her son said to me if I come up and pick you up would you come down to my ma, I think she's going a bit funny. [Interview 20]

Another participant also observed accelerated cognitive changes in her friend. Although her friend had a diagnosis of Alzheimer's disease, there was a sense that the public health measures had exacerbated the trajectory of the condition:

And we know the other woman, she's getting Alzheimer's, [name] and she's a widow, her husband died when he was only [age]. And she's 85 now, 86 and she's a widow all them years, she lives in [area] But like even my other friend, she rang me saying what do you think of [name], she keeps saying the wrong thing and she's telling you the same thing over and over, she's only in the first stages of it like you know. [Interview 20]

The psychological impact could manifest in reflecting on one's own mortality, but not only in the sense of death itself, but the impositions of public health restrictions on the dying process. Being alone and at end of life was considered a very lonely place:

I say most strange things, like I haven't been feeling great and I was just thinking about my demise, I don't know, but that kind of thing comes into my mind you know. [Interview 3]

And I suppose there is that about mortality, the fact that you could get this awful disease, awful virus and you know, the way you would die isn't very nice and your funeral, you know, for all the people, like you'd be on your own. You wouldn't, I mean, I know you have nurses and they're very good and so on. But your family, you would have no family, you know. [Interview 17]

Another psychological impact was related to deaths of friends. Shock was experienced when their healthy friends succumbed to fatal COVID-19 infection.

Very quickly, you know, very, like they [friend] were healthy people. That took a lot of getting used to, you know, that they weren't there anymore. And it probably affected me a bit because I didn't bother about the bridge then [Interview 6]

Experiencing the death of spouses, relatives and friends was perceived as psychologically difficult as the older person was navigating death, dying and bereavement in an unfamiliar context, where normative expectations and experiences were disrupted. This disruption meant that the participants could often not attend the faith and funeral rituals that were traditionally held. In some cases, the participants only heard about the passing of a friend or neighbour after the funeral, and this was perceived as difficult:

Yeah, its unbelievably hard [death of friends and not attending the funeral]. Can you imagine what it's like to know somebody all your life and then all of a sudden they disappear and you only hear about it after they are gone. [Interview 19]

One participant detailed the loss of her husband, who had lived with dementia and resided in a nursing home. The public health restrictions meant visiting was curtailed and she was unable to be with him at end of life. This caused major distress with a lasting impact:

We knew he was never going to get any better but at the same time didn't think he'd go like that with not being able to get into him...I just can't get my head around that I couldn't be with him at the end. Yeah, that's the hardest part. [Interview 11]

Faith practices were important to the participants generally and rituals such as not being able to attend Mass and receive communion were, for some people, very difficult:

Yeah, I'll tell you, the other thing before we go off the churches... it makes me sad that I can't get up to the church and that I can't walk myself up to the church. Because apart from the fact now that you know, it's nearly always closed, but before this, I mean at the start of the pandemic, I couldn't go... if I went and asked, I mean I would be afraid... But that affected me more than anything. Not being able to go to Mass. Not being able to receive the blessed sacrament. [Interview 3]

Overall, not being able to attend funerals or participate in some of the funeral rituals was perceived as difficult and impacted many of the participants psychologically, resulting in sadness at not being able to say goodbye:

But you do miss your friends. I mean I've lost so many of my good friends and I'm so sad when I think of it and not being able to go to the church or be there for funerals, you know. [Interview 2]

An additional source of anxiety was COVID-19 information overload. This could be a direct result of COVID-19 being a recurrent topic of conversation leading to fatigue and avoidance of the topic in conversation because of its psychological impact:

...as time has gone on, they [neighbours] have very little to say. Like they're getting so fed up, they have nothing really to say, you know. And they're grand, some of them will talk but more of them have really very little to say. So it's getting in on people, and they're getting kind of sad and you know, they really don't want to talk much about it [COVID-19] to tell you the truth, you know. [Interview 3]

Too much talk about COVID-19 could also be irritating as it was constantly the subject of other conversations with family and friends:

I have one friend, God bless us and she rings and she has every statistic of the thing. She must sit at the television all day. I just can't take it, you know what I mean. No matter how you change the conversation, she'll come back to it and at this stage I feel, looked, you get the news there, she'd say "I watch the BBC" she says, "at 9 o'clock at night, do you?". "No" I said, "don't we get enough news on the Irish television about the COVID?" you know. ... Yeah, you just get, you know, you get sick of it [listening to news of COVID-19]. [Interview 6]

This fatigue was also demonstrated in receiving constant news reports, which exacerbated anxiety and worry about being infected:

So you became neurotic about listening to the radio and you were going from one news item on the radio to the next news item on the television and ending up depressed with the fact that you were ending up that you couldn't move or you couldn't go outside the door. [Interview 14]

Physical health impact

Some participants observed how COVID-19 exacted a toll on their physical health. This was due to both the physical and spatial restrictions, which curbed previous exercise habits and imposed service access limitations. Physical health could deteriorate as being confined to the house translated to a lowered physical exercise and ability, with some indecision on what is possible:

Well, you see it because you're not physically able to do things because you're not as fit as you were because you're sitting around thinking will I go and try and do this or try not to do that, that type of thing. [Interview 14]

Consequently, some older people reported a decline in mobility during the pandemic period:

[asked if physically not as mobile] Absolutely, I do find that, yeah, yeah.
[Interview 11]

Physical health was also impacted by restrictions in health service provision. Pandemic related curtailments in services to optimise physical capacity translated to a reduction or removal of such supports with reports of participants' decline in physical function:

And at the moment I can't walk. Hoping that... the physio had stopped because of COVID ... Now with a lot of pain and they give me [name of medication] before I do it. I was doing it and then the COVID came in and one of the guys actually got COVID. And of course, they weren't allowed do physio with us and they couldn't sign me off to do it. [Interview 7]

I was to receive physio but when pandemic struck, this was not able to go ahead.
[Interview 15]

However, the participants also demonstrated that they were managing without the usual hospital appointments:

...we had hospital appointments cancelled twice during this and they said, you know, “we’ll let you know the new date”. So that was okay, I had to go along with whatever they said, you know what I mean. [Interview 12]

Practical impact

As discussed in the previous sections, the impact of public health advice relating to shielding translated to curtailment or a revision of mundane instrumental activities of living which encompassed tasks external to the home. Beyond those related to accessing health services, these mainly related to shopping and paying bills. In this regard, older people made choices on how to navigate their daily lives, for example by alternating shopping habits. The excerpt below identifies how increased awareness of risk translated into the practical impact of careful navigation of shopping:

And I still keep that up a bit but I do go to Supervalu now because I find... I know they have a particular time for older people but I find if you pick a particular time, like a Monday afternoon about four, there’s very few people there. And my chemist is down there so I go down and you know, and they have it very well organised. So like I can do that now which is great. I find that that’s my social outing, you know, and that wouldn’t be every week or anything like that. [Interview 17]

Yet, some of the participants identified that they had balanced any practical impact of their everyday lives against the ability to remain independent:

I did it [shopping] mostly myself, as I say I like to be independent. So, I like to do things for myself. I don’t like to be depending on other people, I don’t have to be. [Interview 4]

For some of the participants who experienced reduced mobility or had poor health, the arrival of the pandemic did not signal a tremendous change to their daily routines in terms of leaving the house or social contact outside of the home. For these participants, they already had an established routine with limited social contact which they had become used to:

So before the pandemic I would have been used to not being you know free to go out and that kind of thing. Having to stay in wasn’t as massive a kind of that it would had I had the freedom of going out and about. [Interview 8]

Ways of coping and adapting to the public health restrictions and their impact on the individual lives of the participants is presented in theme two.

In summary, Theme one: Shielding experienced as a social disruption, demonstrates a contrasting of pre-pandemic and pandemic lives. Previous taken for granted geographical and social liberty is experienced as curtailed. The protection of health is the main catalyst in adhering to the public health guidance related to shielding. The impact of shielding was evident in all domains of the participants' previous familiar daily lives as they worked to adapt to the restrictions and continue to preserve health, social connections and ensure their needs (shopping, bill payments) were being met.

THEME 2: COPING WITH AND COUNTERING SOCIAL DISRUPTION

This theme refers to the conscious and active ways in which participants engaged in activities to adapt to, resist, address or avoid the impacts of shielding that challenged pre-COVID-19 social roles, identities or ways of living. This involved the participants using and adapting pre-existing strategies to cope with the impacts of shielding and implementing new and sometimes innovative ways to cope with and counter the social disruptions they experienced. This theme also includes the participants' perspectives on how the pandemic responses were handled at a macro level and what could be improved in the event of another pandemic in the future.

PRE-EXISTING – ADAPTATION

Throughout the transcripts, there were descriptions of how the participants used or adapted pre-existing social support networks, personal resources that were available to them and individual coping mechanisms to counter the effects of shielding. As identified in the first theme, the participants used a “before and after” narrative to talk about the routines that they had prior to the pandemic and the many roles and responsibilities that they fulfilled. Many of these activities were social and recreational although some participants did provide care for their spouses. These daily routines, that were varied among the participants, were shattered with the arrival of the pandemic and required a new routine which had much fewer opportunities for social engagement. These new routines consisted of activities that the participants had engaged in prior to the pandemic but also included new ways of keeping

occupied with some participants taking on small projects (like clearing out the wardrobes) and revisiting past hobbies (like knitting) or taking up new ones:

I started knitting again. I used to knit a lot, I used to knit all their school jumpers and I used to knit all baby, new babies and little booties and I gave it all up when they all got old, you know. And I said to myself god, I said I think I'll give that out to the charity and then I said, when I saw the pattern I said do you know I'll do a bit of knitting. So I started knitting a long scarf like you know and it was kind of white, blue, pink, you know different colours. And my husband was looking at me there this morning, I was doing it for a few, but I believe it's a good thing for you to do, isn't it? [Interview 20]

It [partition between rooms] has sliding doors and they just have to push me into the sitting room and I'm sitting there, you know, but I do keep myself amused. I'm a great reader ... I like the telly and radio and listening to podcasts and that kind of thing. So I keep myself, I'm not bored as such. ... I have always something to do. [Interview 7]

Keeping occupied was an important coping strategy and the participants talked about how keeping occupied helped them to pass the time and break the monotony. Traditional activities like watching television, listening to the radio and reading were talked about but other activities were also identified. Some of these activities took place online including playing bridge online and yoga classes on Zoom. Exercise was repeatedly mentioned as an important coping strategy and most participants talked about how they made sure that they got out, at least daily, for a walk. This was perceived as easier in the early days of the pandemic as the weather was good although the five-kilometre radius posed a challenge for some who did not have access to a green space close by:

I didn't find it a terribly bad experience really and of course the weather was good, being able to get out for walks. [Interview 4]

I went out every day for exercise into the field just outside our door. [Interview 16]

This resulted in some participants changing their walking routes and using fields or football pitches that were nearby. When the weather wasn't as good, the participants talked about their gardens and used these to take brief spells of exercise which was sometimes described as getting a breath of fresh air. Many of the participants referred to their back garden as an important resource that they used frequently and were grateful for throughout the pandemic. Exercise and other activities coupled with normal self-care activities such as

washing, dressing and preparing meals helped the participants to pass the time and get through the day:

Well, I get up about, we'll say nine, right, and I dress, wash and dress and then I have my breakfast and I watch Mass at 10.30 every morning on the television ... And that brings me up to nearly 12 o'clock. Then, I have to get my dinner. I do my own, I cook my own food. ... And then as I say, I can go out into the garden. I have a good big garden, you know. ... I get a bit of exercise and I do a few exercises myself. [Interview 16]

Other participants who were living with a spouse with physical health needs, also talked about their carers from the HSE and how they opted to continue with these services. One participant talked about completing a cost benefit analysis and decided to keep the carers as their benefit as a pre-existing support outweighed the potential risk of them putting her or her husband at risk from COVID-19. As before, the carers calling in everyday helped them to maintain some social connections when they were shielding.

And to be honest, to have the carers coming in every day, even though I find it very intrusive, but I think that kind of was nice, that you were having at least somebody different coming into your home. [Interview 16]

While the participants' longed for a return to normal, they approached the lockdown and their new routines in a positive way with many comparing themselves to other people who might not be as well off as they were. There was a strong sense that the participants felt that everyone was in this together and that they just had to get on with their lives. Throughout the interviews, the participants were generally optimistic and appreciative of the resources they had at their disposal. In many instances, the participants sought out the positives in the situation and talked about how their independence and positive outlook assisted them in coping with the social disruption caused by shielding. In addition, the older participants accepted that there was nothing they could do about the pandemic apart from following the national protocols, and that this included tolerating uncertainty, which helped the participants to cope. Many of the participants described themselves as positive people and talked about how this helped them to cope with the loss of social contacts when shielding. Others mentioned how they were accepting of the situation, independent or motivated which also helped them to cope:

I just think I am accepting you know I accept things you know that is my own way of coping I accept things as they are and think there are things that are a lot

worse. And that is how I have got through life when my husband died it was the same there are people a lot worse off than me you know and I that is my way I am not a worrier but it's not that I don't get upset at times over different things. But I just cope with life as it comes. [Interview 15]

One of the positives that was mentioned frequently was the kindness displayed by friends, neighbours and strangers. While many of the participants had reduced social contacts, this was only in the physical realm and they were able to stay socially connected using alternative modes of communication. The positivity, gratitude and acceptance that the participants talked about, was often set within the knowledge that they knew that they had people around them, that they were supported and that they would get through this:

But if you are asking me what helped me through the last year was... he always would be very specific about when you wake in the morning be grateful for what you have. You have to...you really have to. Because when there's good people around you, what can you do? You really have to be looking on the bright side because people are helping you all the time. [Interview 19]

While inner personal resources were sources of strength and resilience, family support was the most cited external coping mechanism, and for those whose spouse or partner was still alive and living with them, they talked about how family support having made things a little easier. These participants described themselves as 'lucky' and some talked about how tough it might be if they were living alone:

But we would have spent a good bit of time together anyway at home. So it mightn't have impacted on me as much as it would others. [Interview 16]

However, one participant who did live alone suggested that they had become used to living alone and that the pandemic didn't change that. Throughout the interviews there were many references to the support that the participants received from their family with adult children the most frequently mentioned source of both emotional and practical support.

Yes, I feel that and then I have another daughter who comes she will call in in the evening when the other girl is going home early, she calls into me, so I am never in the evenings I am never without you know until about nine o'clock from about seven o'clock there is always some people calling and my son calls. [Interview 5]

NEW WAYS OF DOING THINGS

For the most part, the participants continued to remain independent and managed domestic activities as before within their own homes. The participants remained in contact with their adult children, friends, and neighbours mostly by telephone but also through social media like Facetime and WhatsApp. The participants also continued to interact with their family and friends face to face although these encounters were socially distanced. There were many references to family members calling around to the participants' homes and them chatting in the garden or coming into the house but keeping their distance. In addition, the participants talked about having a cup of tea and chatting to their neighbours over the fence if the weather was fine. All these social interactions helped the participants to stay socially connected to the outside world:

But then I discovered, of course, before that you really don't take much notice of neighbours, then I discovered I had good neighbours who were equally interested in talking to me. So, it was a phone call or maybe a little chat across the garden wall or something like that, it was a great improvement. And then we started to exchange, you know, the news or whatever. And I have a lot of fruit around here and somebody else had a lot of some other kind of fruit and we exchanged things like that. So, it was kind of a nice feeling that we were in it together. [Interview 2]

One participant talked about how they had actually got to know their neighbour better during the pandemic as the neighbour had reached out to them to offer assistance. As mentioned, the participants talked about the importance of their gardens during the lockdown and for many spending time in the garden became a focal point for activities outside the home. While for some of the participants this was part of pre-COVID-19 activities and hobbies, for others there was a new or renewed sense of appreciation for this physical space that they had access to.

Now the farthest I go out to the garden, I'm after being out there now, I use a big tablecloth out there, and I walk up and down there and breath in the air... I'm walking up and down the garden, now I've a long garden there out the back and my husband has it all, he does a bit of gardening, he has it lovely, its full of daffodils there now. And I walk up and down and then I sit down on my little seat for a while or I bring my cup of tea out there and I sit there. So, I feel a bit better now for doing that, you know what I mean. [Interview 20]

In the early days of the shielding experience, the participants were not able to shop for themselves and this activity was taken over mostly by their adult children. While the

participants would have preferred to do this themselves, they didn't risk venturing out in the early days of the pandemic. Where adult children were not able to do the shopping for the participants, there were many instances where neighbours, friends and the Gardai stepped in to do the shopping for them. As the pandemic progressed many of the participants recommenced doing their own shopping but approached it cautiously for health reasons. For example, choosing a time when they knew the shops would be quiet.

They [family] did all our shopping. I didn't go near the shops for that particular lockdown. Well no, I do shop myself [now] but I mean I pick my time, try to pick a time that isn't too busy. Yeah, I mean there's only the two of us so I wouldn't have a huge amount of shopping to do anyway. [Interview 16]

The offer of support for practical tasks was also demonstrated within the community. This could be from neighbours who offered support:

I have really good neighbours and we have a young couple that moved in and they were very conscious of, you know, their older neighbours, and sent a little note around saying if we ever needed anything just... they gave us their contact number. So I suppose in lots of ways I've been lucky. [Interview 16]

Alternatively, five participants noted the active engagement of the local gardai (police) in visiting their homes to assist with various tasks:

And then her daughter over in England, with the last lockdown a couple of weeks ago, she told her "mum, you can't be going to the shops at all" and she got online shopping for her from [name of supermarket] and they're doing that for... this is the third week now. And I said "what am I going to do?" and when the guards came, they call on a different day every week and they called and I said "were you saying that you would do shopping?" "oh yes, if you need it, anything you want". So I said "well if I give out a list" I said "would you get it?" [Interview 13]

But anyway he [Gardaí] called to the door and he was awfully nice and he told me he was up in [area], blah, blah, blah and he said was there anything he could do for me. And I said "no thank you very much, you're very kind". He said "do you want any messages [shopping]?" and I said "no, thank you very much", blah, blah, blah. Anyway, to cut a long story short, a guard has been coming from [area] for the last six or seven months. Community, policing community, keeping an eye, I'm on my own and if I need any messages. They're awfully good, very kind and I couldn't grace them enough. [Interview 3]

As well as shopping, some of the participants also talked about how their adult children also managed some of their utility and other bills when they couldn't make it to bank or post office

themselves due to COVID-19. Support to undertake shopping could also be from family members who assisted in transport and pension collection as well as helping between the weekly shop:

The son comes over on a Friday because Friday is pension day and he comes over on a Friday morning and he takes me to [name of supermarket] for the shopping, and I get my bits and pieces and if I need anything during the week, I just ring him and he brings it to me. [Interview 11]

In terms of paying bills and managing finances, none of the participants reported making formal financial arrangements for third party use of their banking cards. Participants were able to manage their finances themselves, in person:

Well now, I do all that myself, credit union. Banking I do that, and my credit card. [Interview 10]

Some identified that these bills were paid by standing orders [Interview 2], cheques, direct debit or online banking:

Well, I paid most of them [bills], anything I paid by cheque or some of them are direct debit. [Interview 6]

I use banking, 24-hour banking on the phone. [Interview 7]

While adult children provided a certain amount of support before the pandemic, their roles became more significant and in many instances the support they provided increased. There was either an increased amount of practical support or increased social contact, for example, calling around to the participants home in the morning and again in the evening time as well. In addition to face-to-face contact, there was also increased communication mainly through telephone with adult children phoning their parents to check in with them and make sure that they were alright or if they needed anything. When national guidelines changed to allow for closer social contact through a 'social bubble', many of the participants mentioned this as helpful. Here the participants talked about close family members staying with them for longer periods and engaging in activities that promoted social connection and countered loneliness.

USE OF SOCIAL MEDIA AND TECHNOLOGY

The participants talked about the telephone as the most frequent means of keeping in contact with the outside world. Many of the participants had smart phones or iPads/tablets or laptops and were familiar with the common social media applications. The participants used social media to keep in touch with their family and friends and while for some this was a new experience that they had to learn, most were proficient and had used applications like Facetime, WhatsApp and Zoom prior to the pandemic. Many of the participants had adult children and grandchildren who were either abroad or lived 'down the country' and for these, video calls were commonplace and not unusual prior to the pandemic:

My daughter lives in [names county] my daughter in, yeah I've four daughters I mean I would zoom them all. [Interview 4]

Telephone and then we text, you know but nearly always telephone. WhatsApp. Yeah, oh yeah, particularly the WhatsApp. In fact the coverage in certain areas would be poor on WhatsApp sometimes, you know. [Interview 10]

Some participants talked about how they had used computers as part of their work before they retired and although some stated that they were not experts, they could manage the basics. Participants who described themselves as weak or 'illiterate' when it came to using the internet were in the minority. WhatsApp was mentioned frequently and some of the participants talked about the funny videos and images (memes) that were shared by WhatsApp groups which cheered them up. While there was recognition that social media did not replace meeting and talking to people in person, it was perceived in a positive way and a good alternative given the circumstances. One person described technology as 'great' and a 'life saver' adding that being able to see the person you were talking to made a huge difference. This was echoed by a few participants, but as mentioned was not necessarily a new experience for many of those that were interviewed:

Well I don't... I mean I see my, I have two grandchildren and I talk to them, you know, when you can talk to them but it's on the video, you can see them? Oh it was, yeah, it was a life saver. And the fact that you can actually see people when you talk to them. And Zoom, you know, that makes a big difference. So yeah, no, technology was great. [Interview 17]

In addition to keeping in contact with family and friends, the participants also talked about using the internet to source the news, surf the internet, do online shopping, pay bills and

listen to podcasts. One of the participants talked about playing bridge online and how she invested in an iPad for that purpose and also for other activities such as doing wordsearches:

Yes, well you would be still in the club, right, and they'd set up a partner for you, for me, because I had none at that stage. So on a Friday night I would play, if you understand it, I would play with a certain person, not in person. So I don't see them. ... I don't see them, I play with them and then if I want to play during the week by myself, you play with a robot. [Interview 6]

My son did the shopping once a week ... At one stage and then eventually we started to... well my wife did ordering, [online] having the shopping delivered from [name of supermarket] once a week... My son used to deliver the shopping when he was doing it but deliver at the door. [Interview 9]

Shopping online was discussed and while for some people it was satisfactory, other participants suggested that they didn't like it. For example, some older participants found this limiting in terms of choice or being able to check expiry dates:

I much prefer to be able to go to the shops myself. And I think the big thing about online shopping is that you know, you're not going to buy milk that's going to be out of date tomorrow if you go to the shops today. But you have no guarantee that some of the stuff you got in your order wasn't going to be out of date the next day. I found that very frustrating and if they didn't have items that you ordered, you know. [Interview 13]

When I found that online shopping, you'd be looking for a specific [thing] you couldn't get in there, like you were getting a kind of a generic choice, you know. Like if you were particularly interested in a particular brand or a particular cut, you wouldn't see it like. [Interview 18]

Others talked about buying clothes and other goods online using click and collect.

As indicated in the section on the psychological impact of the pandemic, many of the participants talked about the importance of their faith to them and this did not change during the pandemic. Where it was mentioned by the participants, faith practices were integral to their routines prior to the pandemic with many participants attending daily mass at their local parish church. In person attendance was replaced with either virtual attendance at mass over zoom, or the participants watched it on the television. 'Zooming' into mass or watching it on television became part of the participants' routines and some participants engaged in other faith activities such as virtual bible studies:

But once the gym then closed and everything shut down so then you couldn't go to mass you would go to mass on a Sunday and you would meet up with your friends at mass and but now I haven't been to mass since last March. but I get it on my television every morning at ten and then that gets me out of bed in the morning now I will come down and have my breakfast at half ten. [Interview 5]

THINKING AHEAD - LOOKING TO THE FUTURE

For the participants who talked about the future, there was cautious optimism and they looked forward to getting back to normal although they were uncertain about when this would happen or if there would ever be a complete return to the way things were. They also looked forward to the vaccine roll out, knowing that they would be the first to receive it because they were senior citizens. When the participants were asked about how things might be managed differently if there was another pandemic, they struggled to come up with any concrete recommendations. Some who responded to this question talked about the Government's role but were reluctant to criticise them because they understood that everyone was on a steep learning curve and that the nature of the information and guidance was emerging:

God, I hope that never happens [another pandemic] ... I don't know can you put it [public health messages about the virus and what to do] differently. I mean I can well understand the reasoning behind it and it makes a lot of sense, do you know what I mean? [Interview 17]

My outlook is they [Government] are doing their best and that is all they can do and I don't know what else I don't know what can be done different you know. [Interview 9]

Yet, some participants suggested that the Government could have been clearer and stronger with the messages so that people knew exactly what to do in terms of social distancing. Such clarity was important in the context of potential future pandemics:

Yes, I would say that they [Government] could have told us, well they could have given us more instructions as to how to keep safer. Now I know they gave you instructions, but they weren't always realistic in the sense... they never said "don't do this". They would have said it but they weren't strong enough. And I did feel like they could have let us more into information on how we should act. [Interview 3]

But the sooner they get themselves all singing off the same hymn sheet, like the schools reopening was a mess. And the minister to her credit or her discredit said

that she had been talking to the unions... she hadn't. So you can't go off on solo runs when you're dealing with the public like that, you know. [Interview 10]

Another area of concern related to international travel and the easing of the lockdown in December 2020. Some of the participants believed this should not have been permitted at that time and were critical of the government's management of international travel; they believed that airports should have been closed earlier to manage the spread of COVID-19.

When they [government] shut things down they should have shut airports, the whole lot, they should have shut everything down and maybe we wouldn't be in the mess that we're in now... They should have never opened up at Christmas because I think it put us right back to square one again, you know. [Interview 11]
I 18

...the ideal thing would be to spot this thing coming into the country, ring fence it and deal with it [via international travel ban]. [Interview 18]

One participant compared the control of the pandemic in other countries and suggested that similar actions should have been taken rather than having multiple lockdowns:

And then I read in the paper that there's five thousand people after coming through Dublin airport- half of them from holidays! I mean you either do what New Zealand does or what Australia does and they say listen to cure this thing we have to get ahead of it, not behind it and be chasing it by the lockdowns and lockdowns and lockdowns. You have to get ahead of it and try and stop it so your lockdown everything. That's my thoughts. [Interview 19]

Another participant suggested the reduction of restrictions at Christmas was due to a commercial reason rather than public health:

Government made a mistake in December- because of wanting money to come in. [Interview 15]

Other criticisms which pointed to areas of improvement related to the test and trace system. The participant below had required hospitalisation for a COVID-19 infection and was upset that his contacts were not followed up by the Health Service Executive (HSE). The upset also related to the rollout of the vaccine:

I'm critical of the HSE, very critical. Would you believe nobody ever contacted me to ask me who I was with and where I was when I got the COVID? My son tested positive... he was never contacted by the HSE...They [HSE] ran out of [the] vaccine so they had to wait for new supplies to come. That kind of horsing really makes me angry. [Interview 10]

In terms of the participants' experience of the public health measures that were specific to older people, there were only a few suggestions of how things could be done differently. There was a sense that a one size fits all approach was not the most helpful and that categorising everyone over 70 years as being at risk was not the best approach. Here it was suggested that older people are responsible and could manage the public health advice individually without having a blanket rule applied:

Yeah, no it's a very interesting subject when you get involved in it but it's a very difficult one, I see, to get one size fits all. It's a very personal thing. [Interview 14]

One participant emphasised that it is important that community services are not restricted in a pandemic:

There were none [Community home help services]. There was nobody to clean the house. There was nobody to get the shopping. Well, what you were relying on was volunteers who were around the place that would come along. And there was, there were a couple of the younger fry around the place who were, you know, they'd drop the note in the door and they'd say they'd be only too happy to do it for us, you know. But when something goes on for over a year, people get tired [of helping]. [Interview 18]

Another participant suggested that staying active and getting as much exercise as possible was an important strategy for managing any stress caused by the lockdown. In addition, it was suggested that staying positive, accepting the uncertainty and following the public health advice was also an important strategy:

[for older people] I probably advise them to exercise as much as possible but that is I wouldn't be the type nobody would ask me for a lot of advice I wouldn't offer it without you know without being asked that would be probably the best thing. To if the situation occurred and I was asked for advice I would advise keeping active. [Interview 9]

So that's what I'd tell people-worry only when worry comes to you. Keep the chin up and accept the government regulations and you'll be okay. That's all I can say. [Interview 12]

As demonstrated in the participants adaptation to pandemic life, routine was also considered important for coping during the pandemic. When asked about what advice would be given for older people in a pandemic, should one reoccur, in the next quotation, the participant details the structure of his day as a method of coping for older people and keeping a positive attitude:

Oh routine [to cope], yeah absolutely yeah, get up in the morning, get the breakfast ready... The only thing we can do is just keep thinking positive, positive, positive all the time. Get on top of things rather than get you down, you know. [Interview 12]

It was noted by many participants that, in the latter part of 2020, the easing of restrictions for older people was considered a relief. The social bubbles as supported by government in wave two of the pandemic were also seen as advantageous and they relieved some of the distress caused by the social isolation caused by the pandemic.

In conclusion to this theme, the participants described new ways of adapting their lives to the adherence of the public health measures. This involved making particular choices in terms of staying at home, venturing out, accessing support systems and creating new routines. Many participants spoke of increasing their use of virtual communication with family and friends, such as using the telephone, WhatsApp and Zoom as compensatory measures to address gaps in face-to-face communication. In reviewing participants' perspectives of the pandemic, some participants pointed to the impossible task of responding to a novel virus in pandemic circumstances, while others were critical of the lack of clarity of information, decisions made regarding levels of public health responses, contact and trace services and community level services. The vaccination programme was considered a major milestone in combatting COVID-19, however, in the event of future pandemics, their experiences pointed to the need for more clarity, and engaged response systems which avoid repeated lockdowns. In the context of older people, developing routines, keeping connections and a positive attitude were central ways of coping.

SUMMARY OF FINDINGS

- The findings from this study are reported in two themes 'Shielding experienced as a social disruption' and 'Coping with and countering social disruption'.
- The participants used a before and after narrative to describe their experiences before and during the pandemic.
- In the first theme, the impact of the COVID-19 pandemic and the resultant shielding is experienced as a social disruption which impacted on the participants' temporal and spatial possibilities.

- This resulted in disruptions and subsequent losses to the participants' social connections and their geographical life space.
- The participants prioritised their health and closely adhered to the public health guidance to protect themselves and those close to them.
- Shielding from COVID-19 resulted in social, psychological, physical and practical impacts which were challenging to the participants.
- Coping with and countering social disruption involved the participants' using pre-existing mechanisms and new and innovative ways to cope and counter social disruption.
- Pre-existing adaptation involved the use or adaptation of Pre-COVID-19 coping mechanisms which helped the participants with the social disruption caused by COVID-19. This included the use of extant social support networks, personal resources and self-care activities to manage the challenges presented by shielding.
- Many of the participants described themselves as independent and as having a positive outlook and this was perceived as something that helped them to cope during the shielding experience.
- In addition, new coping mechanisms such as socially distanced meetings with family and friends, increased use of their gardens as a social space and greater support from the participants' adult children were new ways of managing and coping with the shielding experiences.
- The use of social media and technology featured strongly in the transcripts as a means of staying in touch with family and friends and for most participants, they were familiar with many of the popular applications such as WhatsApp and Zoom.
- Participants in the study looked forward to a return to pre COVID-19 life and reflected on how the pandemic responses were handled by macro-systems such as the Health Service Executive and the Government.
- Suggestions were made on how older people could cope within the context of future pandemics.

Chapter 4 Discussion

INTRODUCTION

In this study, we explored older people experiences of the COVID-19 pandemic with specific emphasis on their experiences of shielding, a public health measure that required them to stay at home and reduce social contacts during this time. The findings demonstrate that these unprecedented restrictions placed on older people had significant impact which affected their lives, especially within the social domain. The principal impact was in the disruption of the familiar everyday lives of older people. In this context, the lives of older people were transformed as they self-regulated to protect their and others' health and comply with public health restrictions. The findings have shown that this has resulted in shifting roles, identities and ways of living, which contrasted with participants' pre-pandemic experiences. As such, shielding experiences were conceptualised in terms of the encountered social disruption and the resultant actions focused towards coping with and countering this disruption. Thus, while those in the study experienced impacts on multiple domains of their lives, older people demonstrated resilience in the face of the challenges encountered. The aim of this chapter is to discuss older peoples experiences of shielding in the context of the emerging literature in this area.

Public Health Guidance

The National Public Health Emergency Team are tasked in Ireland with advising the Government on public health responses. Taking an epidemiological approach to combatting COVID-19 encompasses a risk management approach. Rothman and colleagues (2008) describe risk as the estimation of how probable an event might occur in a specific time. However, estimating risk also pertains to classifying populations, gender, ethnic groups, age groups etc. who are more susceptible to a disease and identifying appropriate, responsive, and protective measures. In the context of COVID-19, knowledge of the virus and its contagion patterns indicated that social distancing, reducing contacts and crowd avoidance as well as good hygiene practices and mask wearing were protective measures. In addition, older people were identified as a risk population and this was borne out by the disproportionate impact on mortality rates in older people globally, particularly in the initial waves of COVID-19. On the 9th August 2021, the Health Protection and Surveillance Centre

reported 313,876 confirmed cases of COVID-19 and 5,044 probable and possible confirmed deaths (Government of Ireland, 2021a). On the same date, the Government of Ireland reported the administration of 6,154,995 COVID-19 vaccines, with older people being a priority target group at the commencement of the programme roll-out in January 2021. Over the timespan (to date) of the pandemic, infections have demonstrated varying epidemiological curve patterns globally (Gerritsen & Oude Vosshar, 2020; British Foreign Policy Group, 2021; European Centre for Disease Prevention and Control, 2021), with 202,608,306 confirmed cases and 4,293,591 related deaths worldwide (August 9th, 2021) (WHO 2021).

In determining how Ireland would respond to COVID-19, public health guidance was based on a balancing and weighting of risk: the right to freedom of movement and the right to be protected. Consequently, like a myriad of other countries, public health advice from the Irish government recommended shielding as a mechanism to stem infection and protect those deemed most at risk. Initially, the shielding of older people aged 70 years and older had been a strong public health recommendation, (not a legislative imperative), but later iterations of government guidelines facilitated older people to self-determine their own risk and supported the establishment of social bubbles. Many older people, including the participants in this study, made decisions to protect their health and adhered to the public health measures; this supports the high levels of compliance by older Irish people in general (Lalor *et al.*, 2021).

It has been queried whether such restrictions are akin to a double-edged sword; enabling protection of older people but having had unintended consequences (Ayalon, 2020; Pelicioni & Lord, 2020; Kotwal *et al.*, 2021; Levkovick *et al.*, 2021). Research suggests that restrictions, such as shielding, have had a disproportionate impact on multiple dimensions of older people's lives (Lloyd-Sherlock *et al.*, 2020; Chen, 2020) and this study supports such commentaries. Although participants in this study generally complied with public health guidance and were stoic in their adherence, the Alliance of Age Sectors NGOs (2021) reported that older people using their support services, experienced a loss of autonomy related to shielding. It is argued that shielding resulted in unintended consequences for older people such as marginalisation and social exclusion, which had significant impacts on health, well-

being, and quality of life. In this study, participants reported that the discourses of the pandemic rendered them a 'vulnerable' population and this could result in a loss of confidence, an acute sense of being identified as 'old' and a sensitising to one's own mortality. This concurs with other Irish research which comments on a general pandemic ageist discourse, focusing on older person vulnerability and a sabotaging of precious remaining years, resulting in older peoples' acute awareness of their approaching end of life (Alliance of Age Sectors NGOs, 2021). Indeed, there was specific reference in the current study to this sense of time to live life slipping away in the context of adherence with shielding advice and the length of time the pandemic was ongoing.

Older people and the pandemic experience

Our findings demonstrate that older people constructed a temporal journey which drew from the taken for granted liberties of spatial movement and unrestricted social engagement previously enjoyed in their lives. This was contrasted with the limitations of adhering to shielding advice and enabling self-protection. Daily life revolved around the home and even if venturing out, this was with caution, balancing issues such as staying within prescribed geographical zones and considering times when public places (shops/parks) would be uncrowded. The participants presented "home" as a paradoxical space, a place of confinement due to the restrictions but also a place of sanctuary due to the protection of being able to isolate. This temporal journey continued to the participants' hope for a future restoration of their lives in terms of autonomy of choice and face-to-face social connections.

The literature suggests that older people display a good knowledge of COVID-19 and subsequently adhere to public health advice (Chen *et al.*, 2020, Heid *et al.*, 2021, Lalor *et al.*, 2021). Similar to Coroiu *et al.* (2020), the findings in this study indicate the conscious choices older people made to self-protect from COVID-19 infection. Similar findings related to self-protecting and the fear of catching the virus are noted in a qualitative study on older people's COVID-19 experiences in the United Kingdom and Ireland (Brooke & Clarke, 2020). Previous COVID-19 studies in Ireland also indicate that almost 70 percent of older people have left their homes less often, while over 50 percent report restricting their face-to-face shopping habits and their use of public transport (Lalor *et al.*, 2021; Bailey *et al.*, 2021). However,

despite the high levels of compliance, research has shown that not all older people were in support of public health guidance. In Bailey *et al.*'s (2021) study, a quarter of older respondents did not agree with the shielding advice. Similarly, within the general population, there has also been some disapproval regarding the level of public health restrictions with the CSO (2021b) indicating that 13.1 percent of survey respondents felt measures were too extreme, while over a quarter suggested measures were not sufficient.

Our findings indicate that the participants understood the rationale behind the restrictions and were personally satisfied to be compliant and cautious, however, there was some dissatisfaction on the level of macro responses related to both the Government (international travel) and the Health Service Executive (contact tracing). Yet, the older people in this study understood the rapidly changing landscape of COVID-19 and how this impacted on the provision of public health advice and general responses to the pandemic. Many countries have reported relative satisfaction with how governments have managed the pandemic with Denmark receiving the highest approval level (Pew Research Centre, 2021). However, the way governments have navigated responses has also been criticised (Hamm *et al.*, 2020; Miller, 2020; Gardner *et al.*, 2020) including calls for action to mitigate physical and mental health consequences of COVID-19 in the older population, particularly those who do not have close friends or family (Armitage & Nellums, 2020; Liang *et al.* 2021). In essence, careful planning is needed for crises such as the current pandemic with a focus on older person experiences to enable the targeting of specific responses and interventions (Robinson *et al.*, 2020; Rodríguez-González *et al.*, 2020). In Ireland, trust in Government has been mixed with some criticism at the late intervention for older person residential care and as reflected in our findings and Bray & O'Halloran's (2021) study, the late implementation of isolating people arriving from high-risk countries. It is also suggested in the context of nursing homes that COVID-19 has exacerbated existing flaws within the regulatory framework and structural model with calls for reform (HIQA, 2020; COVID-19 Nursing Homes Expert Panel, 2020; Houses of the Oireachtas, 2020).

Ageism has been linked to the way governments and others have treated older people as homogeneous and dependent within pandemic guidance rather than having a right to autonomy and having opportunities to contribute to supporting the response (Ayalon *et al.*

2021; Banerjee *et al.*, 2020; Beaulieu *et al.*, 2020a; Pentaris *et al.*, 2020; Reynolds, 2020). Similar observations have been made in Ireland with the Alliance of Age Sectors NGOs (2021) noting the lack of older people's voices in political decision making and calling for representation in future decisions both within and beyond the pandemic. Even within healthcare, ageism has been identified as some countries have selectively admitted younger people to hospital and have made life or death decisions (i.e. ventilation, resuscitation) based on ageist bias (Maltese *et al.*, 2020).

Impact on Health

The health impact on older people due to community-based shielding has been noted in many studies (Lim *et al.*, 2020; Gerritsen & Oude Voshaar, 2020; Portacolone *et al.*, 2021; Ayalon & Avidor, 2021; Okechukwu, 2021; Lalor *et al.*, 2021). The most severe impact has been the consequences of limitations on face-to-face social engagement with the Health Service Executive (2020a) reporting the potential negative physical, psychological, mental health and social impacts of shielding and other public health measures on older people.

Our findings showed a significant disruption in the older participants' daily quality of life (QoL). QoL is integrally linked to social isolation, loneliness, mental health, physical activity and health as well as social connection, social support and the experience of loneliness (van Orden *et al.*, 2020; Bailey *et al.*, 2021). Like the experiences of the participants in this study, other studies have demonstrated that the QoL of older people has been impacted during the pandemic with satisfaction with social interaction being a key variable for wellbeing (Macdonald & Hülür, 2021; Siette *et al.*, 2021). While the older people in the current study reported a range of psychological responses to shielding, none reported that they had been diagnosed with clinical depression or other mental health difficulty. However, the literature demonstrates that the severity of depression is linked to a poorer QoL both before and during the pandemic (Sivertsen *et al.*, 2015; Siette *et al.*, 2021). Social activities, supportive relationships and levels of loneliness have been linked to QoL (Ward *et al.*, 2021) and the pandemic has negatively impacted on Irish older people's QoL with 50 percent pointing to a deterioration, while 10 percent indicated it as "much worse" (Bailey *et al.*, 2021). This

reduction was associated with declines of both physical and mental health as well as the experience of loneliness (Bailey *et al.*, 2021).

Social isolation and loneliness: Impact on psychological health and mental health

Social isolation may be experienced due to role transitions, physical or cognitive changes or ageism (Malik *et al.*, 2020; Smith *et al.*, 2020). By far, the greatest impact of shielding has been on the psychological and mental health of older people caused by social isolation and loneliness. Pre-pandemic research demonstrates that older people are at a relative higher risk of social isolation with less relationships (Smith *et al.*, 2008) and an increased perception of loneliness (Victor *et al.*, 2009) than their younger counterparts (Courtin & Kapp, 2017). Loneliness and social isolation are considered serious public health challenges which impact on premature death, increased risk of dementia, heart disease, stroke, depression, anxiety, and suicide (National Academies of Sciences, Engineering, and Medicine, 2020) as well as an impaired immune function (van Orden *et al.*, 2020).

Social isolation and loneliness were reported by the participants in this study and its impact ranged from being stoic to being anxious and distressed due to the lack of familiar social connections. Although, social isolation has not received major prominence as a social determinant of health, recent research has linked its mortality impact as equivalent to risk factors for poor physical activity, smoking and obesity (Holt-Lunstad *et al.*, 2017). For instance, Holt-Lunstad *et al.* (2015) undertook a review of 70 prospective studies and identified that the risk of death for older people increased by 26 percent for reported loneliness, 29 percent for social isolation, and 32 percent for living alone.

Research has shown that varying levels of distress were evident in older Irish people as there was a seven-fold demand on helplines run by non-government organisations representing older people (Alliance of Age Sectors NGOs, 2021). Moreover, the Central Statistics Office (2021b) reported 32.4 percent of people ages 70 years and older experienced a decline in well-being and mental health because of pandemic living. Similarly, the American Association of Retired Pensioners (2021) identified that 57 percent of those over 50 years felt frustrated due the pandemic, although younger generations (18-34 years) reported a higher level of

isolation (48% as opposed to 40%). Although our study demonstrated the negative impact of pandemic living in both genders, other studies have demonstrated a higher level of negative emotions, such as anxiety, stress, isolation, a lack of motivation, sadness and feeling overwhelmed in females (AARP, 2021). In Ireland, the experience of loneliness has been reported during the pandemic, with Bailey *et al.* (2021) noting a 40 percent rise in shielding related mental distress with 82 percent disclosing increases in low mood some of the time or often. Findings in a separate TILDA study on pandemic experiences of older people (Ward *et al.*, 2021), pointed to women being significantly impacted while those living alone had higher levels of loneliness. This contrasts with the accounts of some of the older people living alone in this study who indicated that pandemic living did not impact very much on their daily life experiences. Other studies have shown that the disproportionate experience of loneliness transcends gender, however, older people in black, minority and ethnic groups can be more susceptible to loneliness (Victor *et al.*, 2021).

In a large online survey study (n=1679) in the Netherlands, older people reported experiencing greater loneliness during the pandemic and, similar to the observations in this study, the loss of close friends and worry regarding themselves or loved ones catching COVID-19 caused distress (Van Tilburg *et al.*, 2020). While the adverse impact of restrictions on the experience of loneliness is reported in multiple studies (McDonald & Hülür, 2020; Luchetti *et al.*, 2020; Kotwal *et al.*, 2021), the sustainment of desired social communication does provide a protective factor (Macdonald & Hülür, 2021) with the quality of such connections suggested as central to wellbeing (Vahia, 2020). There were multiple instances of the participants engaging in social interaction, with a high use of digital technology and social media platforms both to maintain social connection and to support information seeking.

Prior to the pandemic, the older people in this study were mostly independent and had extensive social networks which they interacted with frequently. The public health guidelines impacted severely on these social networks not only impacting on the participants interpersonal experiences but also the activities that they engaged in. This significantly decreased the number of social contacts that the participants had but also the overall quality of these interactions where they existed. Like the participants in Costello *et al.*'s (2021) study, opportunities for social engagement outside the home disappeared resulting in social

isolation and boredom. In tandem with this, there appeared to be an increased dependence on adult children for social contact. While the participants talked about staying in contact with their friends by telephone or virtually, physical contact was reduced. While physical contact is important, the activities associated with this contact (outings, dining) were also important highlighting not just the importance of interpersonal relationships, but the contexts within which they occur. In addition, the reduction in social contacts that older people engage with daily in a casual way, for example meeting people opportunistically when out shopping, may also increase their sense of isolation. Intimate and peripheral members of older peoples' social networks are important and contribute to a sense of wellbeing (Bruggencate *et al.*, 2018). However, reduced access to peripheral contacts and greater dependency on intimate contacts may have had a negative impact. This may have been worsened by the lack of physical contact with intimate and close relationships. Furthermore, Bruggencate *et al.* (2018) also outline the importance of reciprocity, with the older person being a source of support and friendship being important to wellbeing as well. However, the capacity for reciprocity was reduced by the need to self-isolate. Brooke and Jackson (2020) suggest that older people who had not reported being lonely prior to the pandemic may be disproportionately affected by social isolation requirements. This may also be reinforced by ageist discourses which render the social activities of older people as either non-existent or unimportant (Brook & Jackson, 2020).

A particular feature of the experiences of older participants in this study, was the feeling of missing family events and in particular, grandchildren's developmental milestones. This concurs with other studies which report that older people missed meeting and physical contact with family (children and grandchildren) and friends (Heid *et al.*, 2021; Age UK, 2020). Irish studies demonstrated similar limitations on social activities since the COVID-19 outbreak. For example, over 60 percent of older people within the TILDA study report based on COVID-19 experiences, described discontinuing visits to family members, while 80 percent of the participants had not visited friends. In addition, there was a doubling of the average University of California, Los Angeles Loneliness scale experienced by respondents during COVID-19 times than reported in previous TILDA longitudinal studies (Ward *et al.*, 2021). One small study with 93 older people in the United States found the strength of the relationships rather than social engagement moderated the experience of loneliness (Krendl & Perry,

2021). A second study (n=79) undertaken in the San Francisco Bay area identified 40 percent of participants were socially isolated, while over 50 percent had experienced loneliness at least once due to the restrictions of COVID-19 and these older people were more likely to experience worsened depressive symptoms (Kotwal *et al.*, 2021).

The participants in this study reported regular contact with family, friends, and the community. Kimura *et al.*, (2020) suggests that frequency of contact at a minimum of once a week is necessary to avoid negative impacts on older people's mental health. However, longer durations of public health measures may increase mental health challenges and reduce quality of life, increasing the risk of isolation and loneliness (Roy *et al.*, 2020; Stolz *et al.*, 2021; Haider *et al.*, 2020; Hamm *et al.*, 2020; Vahia *et al.*, 2020) although one study identified an increasing resilience and adaptability over time for some participants (Kotwal *et al.*, 2021). This points to the need to approach older people's responses on an individual level, assessing emotional coping, resilience and accessible supports with a focus on screening for social connections with consequent targeted action (Smith *et al.*, 2020).

Other pandemic studies have considered social isolation, loneliness and the impact on mental health (Heid *et al.*, 2021; Music, 2020; Bailey *et al.*, 2021; Ward *et al.*, 2021; Okechukwu, 2021). While, the participants in this study demonstrated worry, anxiety and some distress (bouts of crying), this did not deteriorate to significant mental health difficulties that necessitated medical intervention. Although experiences of mental health difficulties were not significant in this study, DeLooze & McDowell (2021) reported depression as a significant pandemic consequence, with one in five older people exhibiting clinical symptoms of depression, particularly if living alone.

While international studies show that levels of depression and anxiety are higher in younger age groups during the pandemic period, Vahia *et al.* (2020) argues that it is important to understand the resilience and wisdom of older people so that strategies can be shared with those who are less resilient. Such resilience has been linked to both internal factors (physical health, coping, personality) and external factors (social supports, financial sufficiency, connections) (Laird *et al.*, 2019). Yet despite having greater levels of resilience, the continued longevity of the pandemic has had an increasing negative impact on older Irish people

particularly after the third wave (Alliance of Age Sector NGOs, 2021). The mental health impacts of shielding can similarly contribute to sleep disorders and poorer sleep quality (Sepúlveda-Loyola *et al.*, 2020) especially if living alone (Goodman-Casanova *et al.*, 2020). Consequently, in striving to protect older people from infection, this study, like other Irish and international studies, has demonstrated that there were unintended consequences in terms of exclusion, isolation, and quality of life deterioration.

Bereavement is also a recognised risk for mental health decline, with public health restrictions on rituals such as funerals and not having face-to-face support being linked to the risk of complicated grief and prolonged bereavement disorder (Age UK, 2020; Mortazavi *et al.*, 2020), particularly for those with pre-existing mental health issues (Joaquim *et al.*, 2021). One participant recalled the stress of her husband being a resident in a nursing home, where he died before she could say goodbye. Other participants reflected on losing friends during the pandemic and the distress at not being able to attend the funeral. For family and friends, not engaging with such familiar rituals can lead to upset, distress and even mental health difficulties (Chew *et al.*, 2020; Alliance of Age Sectors NGOs, 2021). Being able to participate in meaningful ways of saying goodbye is important and contributes to social solidarity (Burrell & Selman, 2020). Ireland has a ritualistic approach to funerals; for many, it is rooted in the Catholic tradition of paying respect to the family, wakes and saying the final farewell (Specia, 2020). In essence, the Irish funeral represents a communal mourning which was fractured since the Irish government restricted attendees in late March 2020 with O'Mahoney (2020) noting this as the public good triumphing over private grief. While live streaming of funerals was common and is noted to alleviate grief in COVID-19 times (Burrell & Selman, 2020), this was not identified as being availed of by participants. In some cases, the participants reported that they had not heard about their friends' death until after the funeral further emphasising the impact of social distancing and the resultant social isolation.

Similar reflections were identified by participants in relation to their inability to physically attend their church, particularly in the context of attending mass. It is noted that coping strategies in times of personal insecurity, such the context of COVID-19, includes drawing on support from religious affiliation (Fuller & Huseth-Zosel, 2021; Molteni *et al.*, 2021). Moreover, research demonstrates that religiosity and spirituality can reduce negative health

outcomes and alleviate the impact of social isolation and loneliness in pandemic times (Lucchetti *et al.*, 2021; Koenig, 2020). For the older participants who identified missing such activities, they would have indicated a long history of regular attending religious ceremonies and detailed the comfort that such engagement brought them.

Many studies demonstrate the major impact of pandemic living, related to shielding, on psychological and mental health. While addressing this in pandemic times is fundamental, research also points to the need to include post pandemic rehabilitation as studies on the mental health impact of previous SARS epidemics demonstrate an increased prevalence of long-term emotional and psychiatric morbidity (Mak *et al.*, 2009).

Physical impacts

Physical activity impacts well-being and QoL particularly in the context of physical and mental health (Jiménez-Pavón *et al.*, 2020). Studies indicate that older people who were less active in the pandemic reported reduction in subjective wellbeing and psychological health (Suzuki *et al.*, 2020; Sepúlveda-Loyola *et al.*, 2020) while depressive symptoms have been associated with a reduction in physical activity (Pérez *et al.*, 2021). Ward *et al.* (2021) indicates that Irish older people rated their physical health lower when there were higher levels of loneliness experienced. Findings in this study point to a restriction of movement, although some participants detailed ways to counteract the physical restrictions; spending time gardening and going on walks at quiet times were some of the strategies used. While some participants did compensate to adapt to restrictions on physical activity, others did not. Bailey *et al.* (2021) reported that there was a 40 percent reduction in physical activity of older service users, with 70 percent having less or no exercise and one third reporting not leaving their homes at all. Consequently, the impact of shielding translated to some participants noting a physical decline in their health. Such decline can relate to mobility, general fitness, and low energy (Bailey *et al.*, 2021). In addition, the general reduction of mobility of older people can contribute to cardiovascular decline, sarcopenia, obesity and accelerate frailty conditions (Chen 2020; Lippi *et al.*, 2020; Jiménez-Pavón *et al.*, 2020; Boreskie *et al.*, 2020; Davies *et al.*, 2020).

Accessing health

In 2020, the United Nations expressed concern that the transformation of health services in responding to COVID-19 could have a consequence on care of older people's pre-existing health, with the potential of disease exacerbation as well as delayed identification of emerging health conditions. Some of the participants in this study related how their own 'usual' care was interrupted, or their health deteriorated or that they observed health deterioration in their friends. This concurs with other findings; for example, Bailey *et al.* (2021) identified that 57 percent (87/150) of service users had a scheduled healthcare appointment cancelled while just over 16 percent did not seek assistance for emerging health issues due to the lack of service or fear of catching the virus. While none of the participants in this study reported being a user of older person day care services, their withdrawal has been identified as a negative significant COVID-19 action (Alliance of Age Sectors NGOs, 2021).

Some participants who were in receipt of COVID-19 home care expressed concern about the continuance of such services during the pandemic. It was considered a balancing of decision with concerns about the contact risk related to incoming (sometimes multiple) formal carers as opposed to trying to manage care on their own. While no participant reported a suspension of care, a review at the beginning of the first lockdown stated that homecare was interrupted for 11,300 older people in Ireland (HSE, 2020c), leaving both the older person and/or informal carers with additional caring responsibilities. The restriction or removal of such care has been argued as significantly impacting older people's rights (Pentaris *et al.*, 2020).

Resilience as the capacity to cope

While there were multiple accounts of the impacts of shielding by the older participants, there were also narratives of how positive adaptive approaches were mobilised. Compared to younger populations, and contrary to a dominant fatalistic view of older person vulnerability inherent in some older person literature (Heid *et al.*, 2021; Liang *et al.*, 2021) and social media (Mailk, 2020), older people appeared to demonstrate a higher level of resilience and coping ability during the pandemic (Czeisler *et al.*, 2020; AARP 2020; Fuller & Huseth-Zosel, 2020; Lind *et al.*, 2021) and were more stoic (Petretto & Pilli, 2020). Resilience is considered to

fluctuate during the lifespan and can be diminished due to chronic illness or functional limitations (Lee *et al.*, 2020b; Chen, 2020). The older people in this study described various ways of coping and their ability to cope in the pandemic was also not considered challenging by some participants, although all missed face-to-face social connections. Some, who had lived alone or had health issues which prevented leaving the home, stated that they had not observed much change due to shielding as their daily lives generally remained the same.

Like other studies (Fuller & Huseth-Zosel, 2021; Brooke & Clarke, 2021), important ways of coping in this study were identified as maintaining a routine, keeping oneself busy in the house, through pastimes or exercise, and maintaining a positive outlook. Although keeping informed was important for the older participants in this and other studies (Goodman-Cassanova *et al.*, 2020), some participants identified weariness of the common conversational or media attention to COVID-19. Moreover, the changing guidelines over the course of the various pandemic waves could prove confusing. Mohammed *et al.* (2021), observed in a study of COVID-19 information overload, that the frequency and source of pandemic information could lead to fatigue and confusion. Such confusion has been exacerbated by what Rathore and Farooq (2020) term an “infodemic” which enables false news, dubious theories, and baseless commentaries to spread in common discourse, leading to anxiety and fear. In addition, it is noted that the ability of people living with dementia or with cognitive challenges to understand and comply with COVID-19 information and the rapidly changing guidelines can be difficult (Chen, 2020; Hong & Kim, 2020)

Another factor which assisted enabling resilience and coping in the pandemic time was the support given by other people. COVID-19 mobilised the social capital within communities which is described as the “networks together with shared norms, values and understandings that facilitate co-operation within or among groups” (OECD 2001:103). This could comprise family members, friends, neighbours, or community-based organisations/groups. Participants described the emotional and practical help given to both manage and adapt in the pandemic. For example, a quarter of the participants in this study reported having the Gardai come to their homes to ask if they needed any practical help. While this intergenerational and community solidarity forms a cornerstone of the bonds, bridges and linkages inherent in social capital, this was not without challenges. For example, the pressure

of increased responsibility on family carers increased (Family Carers Ireland, 2020). Moreover, as also noted in the Alliance of Age Sectors NGOs' (2021) findings, some participants in this study reported that their historical support in areas such as minding grandchildren ceased. Like other studies (Brooke & Clarke, 2020; Chen, 2020; Goodman-Cassanova *et al.*, 2020; Fuller & Huseh-Zosel, 2021), family, friends and community networks of support enabled a tolerance of shielding and helped maintain a positive perspective. However, our findings also concur with other older people's desire and anticipation for a return to normal, unrestricted lives (Alliance of Age Sectors NGOs, 2021; Brooke & Clarke 2020).

Resilience and the capacity to cope was also enhanced by the engagement with technology. This involved various mediums to keep connected (e.g., telephone, WhatsApp, Zoom) as well as using technology to undertake shopping and pay bills online or have direct debits set up. Despite the increased use of technology by participants and their familiarity with many of the social media applications, in Ireland, there remains a digital divide due to issues such as a lack of familiarity and use, broadband access and quality and having the technology itself. Doody *et al.* (2020) reports that 30 percent of Irish people over the age of 50 and who are living alone, do not have access to the internet. In addition, access to the internet decreases as people age with only 38 percent of people over the age of 80 having access (Doody *et al.*, 2020). Moreover, Pentaris *et al.* (2020) observe, digital exclusion is starker in those who have decision making capacity challenges or those with various dependencies on carers. Even though participants in this study and other Irish evidence (Alliance of Age Sectors NGOs, 2021) reported an increase in use and familiarity of telephone and digital communication modes, there was a reality that these were an inadequate substitute to having family and friends' physical company. In addition, to a digital divide between younger and older age groups (UN, 2020), Ireland has an uneven broadband coverage and requires an upgrading of infrastructure to enable broadband access equality (Department of Environment, Climate & Communications, 2020). Within the context of virtual healthcare, none of the participants spoke of engaging in consultations remotely, although, this was a practice in some areas (HSE, 2020b) while it is recognised that e-health in Ireland is at an early developmental stage (Jacquemard, 2021).

Safeguarding

Although there are only a few studies of elder abuse in the COVID-19 pandemic, a heightened risk is proposed (Malik *et al.*, 2020; Chang & Levy, 2021; Tamblyn Watts, 2021; Editorial, 2021), particularly in the context of increasing age (Du & Chen, 2021). An additional consideration is that while abuse risk is increased in disasters such as pandemics, risk can be sustained in the aftermath of the crisis (Elman *et al.*, 2020; Peterman *et al.*, 2020). Thus, while prevention and early intervention are crucial, so too is managing long-term risk following a pandemic.

In this study, none of the participants reported any form of personal abuse. As discussed, there appeared to be good circles of support in family, friends and community networks and although it was noted that some services were restricted, this was not considered to have a major negative impact. However, it is notable that the participants in this study were, in general, independent and were able to adapt their previous lives to the guidance of public health measures.

In relation to the perpetration of abuse during the pandemic, there has been a marked increase in demands on Irish family violence services, such as Women's Aid, so it may be that safeguarding issues for older people have simply remained invisible. Moreover, the United Nations has expressed concern over violence against women during COVID-19, entitling this the "shadow pandemic" (United Nations Women, 2020) while a June 2021 editorial in the *Lancet* identified elder abuse as the "second shadow pandemic". In Ireland, a gap in identifying any safeguarding concerns may be due to a reduction in the availability of response services (due to COVID-19 redeployment) and a case backlog in formal Safeguarding services (Brennan *et al.*, 2020; Reilly, 2021). It is also recognised that risks of elder abuse are associated with internal factors (cognitive and physical dependency of the older person) and caregiver stress as well as social isolation (Makaroun *et al.*, 2020). Other factors such as economic pressures due to pandemic related income reductions and recessions (Makaroun *et al.*, 2020; Du & Chen, 2021), increases in substance abuse (Zaami *et al.*, 2020; Abramsom, 2021) can exacerbate the risks for abuse.

As safeguarding draws on the principles of human rights, equality, equity, autonomy, and self-determination, it may be argued that the strong Government guidelines (particularly at the beginning of the pandemic) impacted the conditions of choice for older people, who felt obliged to follow the public health restrictions. The right to move freely has been shown to homogenise all older people, who felt invisible and “cancelled” during the pandemic (Alliance of Age Sectors NGOs, 2021). Some older people in this study detailed experiences akin to being imprisoned while the Alliance of Age Sectors NGOs (2021) describe their older service users as feeling “locked up”, losing confidence in themselves and their ability to be sociable diminished while being rendered voiceless.

A look to the future

Participants in the study were cautiously optimistic about emerging from the pandemic and looked forward to resuming familiar, unrestricted lives. It was recognised that a major step in the return to normality was COVID-19 vaccinations. At the end of 2020, several vaccines were produced and were subsequently granted licences by pharmaceutical regulatory authorities, however, with global demand, the pace of vaccination roll-out differs in each country. This noted, age, nursing home residents and front-line healthcare workers have been a universal vaccination programme priority. A complicating factor in public health responses has been the rise of COVID-19 variants (ie B117, B1351), which have demonstrated a higher transmissibility rate. Due to the slow increase in immunity and evolutionary virus survival, additional variants may still emerge, which may impact on the efficacy of current vaccines (Priesemann *et al.*, 2021). At the publication of this report, the government anticipates a booster vaccine campaign in the autumn of 2021 (Donnelly, 2021b).

When older participants were asked what advice, they would offer older people if a pandemic occurred again, there was an emphasis on keeping a positive perspective and keeping a routine, maintaining connections, keeping busy and taking exercise. This resonates with their own experiences of structuring their day as described in the resilience demonstrated in the previous section. Similar observations have been noted in the literature (Wu, 2020; Roy *et al.*, 2020; Brooke & Clarke 2020; Fuller & Huseth-Zosel, 2021).

Conclusion

At the time of data collection, the world was a year into the COVID-19 pandemic, with waves of infection leading to tightening or relaxing of the severity of public health restrictions. At the point of writing this report, COVID-19 cases and hospital admissions have again risen, primarily due to the Delta variant. Ireland's uptake of the vaccination has been robust with the European Centre for Disease Control and Prevention (2021) reporting a 100 percent uptake in Irish people aged 70 years and above and 99.4 percent in the 60-69 years age cohort. It is notable that following the vaccination of older people, case infection rates and hospitalisations had occurred in younger age cohorts. For example, the mean age of confirmed COVID-19 cases uploaded to the COVID Care Tracker (CCT) from 26/07/2021 up to midnight on 08/08/2021 was 28 years (HPSC, 2021c). Commentaries on this generational shift in infections, deaths and hospital admissions have pointed to the impact of the vaccination programme in providing protection against COVID-19. However, it is notable that in week 33, 2021, there were 11 outbreaks reported in nursing homes (with 56 confirmed cases) and two in community hospitals and long stay units) 15 confirmed cases) (HPSC, 2021c). Moreover, it has been reported that the incidence is rising in all age groups in August (Glynn, 2021).

As global societies slowly emerge from the pandemic, particularly in the context of vaccination roll out, older people's experiences are important to acknowledge and validate and findings from this study may be of use to both post COVID-19 rehabilitation pathways and future approaches to pandemic related public health measures. Undoubtedly, the experience of the pandemic has highlighted pre-existing service issues (home care service provision fragmentation), digital divides and the lack of older people's voices in political decision making. In addition, the lessons learned in macro-responses, such as efficient track and trace systems, international travel restrictions and precautions and integration of care can serve as action plans for similar situations in the future. Having such experience has proven beneficial in countries who have previously had pandemics (Chan *et al.*, 2021; Anttiroiko, 2021).

The public health restrictions have identified the resilience of older people, particularly in comparison to other age cohorts, but has also demonstrated the need not only to provide information and guidance but to respect self-determination (Doraiswamy *et al.*, 2020). In this

context, older people can make decisions to build social networks and activities based on their own assessment of risk. Policy should emphasise the need to re-orientate daily life and partake in activities that support older people's mental health, underpinned by promoting a positive attitude and self-identify while also acknowledging the need to support those who may struggle to cope. Developing resilience through a multi-level response should be ingrained at multiple levels: individual, community, healthcare systems, economic systems and at national levels (Chen, 2020).

The lessons of the pandemic should also emphasise the need to move from a reliance on healthcare delivered face-to-face. This encompasses enhancing access of virtual methods (broadband, equipment availability, familiarisation) while building on the social capital of communities and creating relevant synergies between healthcare and community groups (Smith *et al.*, 2020). For example, the increased demand on older person helplines demonstrates an increased need for support and such collaborative synergies can enable early referrals and responses from healthcare and other support agencies. In conclusion, the COVID-19 public health restrictions introduced in March 2020 have demonstrated both the resilience of older people but also the impact of efforts to self-protect through methods such as shielding. Introducing proactive interventions and supports early, based on building resilience, supporting optimum health capacity and QoL and integrating services while maximising technological supports, can greatly enhance older people's life world in pandemic situations. Moreover, from national policy and guidelines down to individual health and social care contexts, the voice of the older person should be elicited, heard and valued to enable rights- based approaches acknowledging the heterogeneity of this population.

Limitations of the study

As with all research, the study findings should be considered in light of the following limitations:

- The study had a sample size of 20. The narratives offered by participants provided valuable insights and findings reflected those in other studies. However, the sample size was modest and represents a limitation in findings.
- Participants were recruited by community nurses. While the inclusion criteria were identified, there may have been a selection bias and two participants were younger than aged 70 years.

- The sample was recruited from a relatively small geographical area in Dublin. The sample reported having good support networks and had access to gardens and public green spaces, which is not reflective of the context for many older people.
- While some participants reported living with chronic conditions, which have varying impacts on their quality of life and independence, the sample does not represent the experiences of older people who have heavy dependence on others, those whose services were withdrawn or those with cognitive challenges (including dementia). Nor did any participant report having sought services because of pandemic stress (physical, emotional, or mental health related) or concerns regarding safeguarding issues.
- Due to pandemic restrictions, interviews were undertaken by telephone. It may be that interviews conducted face to face may have provided a different interpersonal dynamic and produced additional data. This noted, it is acknowledged that in qualitative research of the type conducted herein, data is co-produced in the moment of interview and therefore not reproducible outside of a particular research interview context.

Glossary

Elder Abuse: “...any act, or failure to act, which results in a breach of a vulnerable person’s human rights, civil liberties, physical and mental integrity, dignity or general well-being, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative. Abuse may take a variety of forms.” (HSE Social Care Division, 2014:8)

Epidemiology: the incidence, prevalence and control of a disease.

Quality of Life: “...an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.” (WHO 1998:3)

Safeguarding: “Putting measures in place to reduce the risk of harm[/abuse], promote and protect people’s human rights and their health and wellbeing, and empowering people to protect themselves”. (Mazars *et al.*, 2020:28)

Shielding: Also described as stay at home orders, cocooning or sheltering in place. Shielding entailed individuals at higher risk of contracting a severe case of COVID-19 remaining at home and limiting face-to-face interactions. The purpose of shielding is to reduce the number of severe cases within a population and reduce pressure on the public health system (Social Science in Humanitarian Action 2020).

Social Capital: “...an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.” (WHO 1998:3). Social capital as social context that has productive benefits which includes the solidarity or goodwill between people and groups of people as well as an individual’s exercise of social responsibility and concern for others.

Support bubbles: Social connections to support those who risk isolation. In Government advice (19th October), the older person can form a bubble with one other household (of any size) if living alone, living with an adult they provide care for (for example a dependent adult relation or a partner with dementia) or living by him/herself and have a carer or carers who support the older person, including a live-in carer.

Vaccines: Biological substances developed to protect against bacterial and viral infections. Vaccines work with the body’s immune system to develop robust responses to the pathogen. The body is equipped with a complex immune system that can recognise pathogens and launch a robust defence through antibody production and confer protection against reinfection by the same virus or bacteria; each response must be specific to the individual pathogen. Vaccines may be developed in multiple ways, but their focus is to enable the body to withstand an infection by enabling a memory response without causing the disease.

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Appendix 1

Types, dose, and effectiveness of COVID-19 vaccine types currently available or in trials until application for drug approval. (Katella, April 7th, 2021)

Type	Dose	Effectiveness
<i>Pfizer Biontech (mRNA)</i>	2 doses	95% efficacy in preventing COVID-19, with 100% effectiveness at preventing severe disease.
<i>Moderna (mRNA)</i>	2 doses	94.1 percent efficacy but reduces to 86.4% for over 65 years.
<i>Oxford AstraZeneca (Carrier vaccine)</i>	2 doses	76% effective against reducing the risk of symptomatic disease, 100% against severe disease. 65% effective in preventing COVID-19 in over 65 years. Phase 3 demonstrates 91.3% effectiveness preventing the disease for 6 months.
<i>Johnson and Johnson (Carrier vaccine)</i>	One dose	72% efficacy and 86% against severe COVID-19 infection
<i>Novavax (Protein adjuvant)</i>	2 doses	96.4% at reducing in reducing mild or moderate disease. 100% effective against sever disease.