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The COVID-19 pandemic and vulnerable older persons: impact of a public health emergency on nursing homes and geriatric rehabilitation

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5

Priority measures to prevent infections and maintain residents' well-being during COVID-19 outbreaks in nursing homes: Consensus among staff and resident representatives determined in an online nominal group technique study

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ABSTRACT

Background: COVID-19 infection prevention measures can negatively impact nursing home residents' well-being. Society has been concerned about the imbalance between infection prevention and residents' well-being, and about nursing home residents' autonomy in COVID-19 policymaking.

Objective: This study explores consensus among nursing home staff about which measures they found to be most important in contributing to preventing infections and to maintaining well-being of residents during COVID-19 outbreaks. In addition, this study explores the decision-making processes regarding COVID-19 measures and the involvement of residents or their representatives.

Design: Mixed methods based on an online nominal group technique.

Setting(s): Dutch nursing homes, June–November 2020.

Participants: Managers, policy advisors, elderly care physicians, psychologists, a spiritual counselor, nurses, care assistants, and resident representatives ($n = 35$).

Methods: Four panels from the viewpoint of infection prevention, and four panels from the viewpoint of well-being were performed with 3 to 7 participants per panel. Participants individually selected the measure they found most important, discussed these measures together in an online conversation, and rated the importance and urgency of these measures during COVID-19 outbreaks on a 5-point Likert scale. The measures that were rated as (very) important and (very) urgent by all members of that panel were defined as 'prioritized in consensus'. Panels also discussed the decision-making process regarding COVID-19 measures and the involvement of residents or their representatives. These conversations were transcribed verbatim and thematically coded using an inductive approach.

Results: The infection prevention panels prioritized isolation measures; testing measures; testing and isolation combinations; use of personal protective equipment around (suspected) infected residents; and preparation for outbreaks by COVID-19 outbreak teams. The well-being panels prioritized cohort isolation, testing combined with cohort isolation and with isolation in residents' rooms, exceptions to visitor bans, maximum numbers of visitors, and registration and accompanying visitors to the residents' rooms. Resident representatives and staff were dissatisfied with their reduced involvement in policy making during the first months of the COVID-19 pandemic, although they understood that decisions had to be made quickly.

Conclusions: Staff and resident representatives should be involved in COVID-19 policy making. According to them, priority COVID-19 measures should include: cohort isolation, testing and isolation combinations, use of personal protective equipment, crisis management by COVID-19 outbreak teams, and nursing home visit regulations and instruction of visitors. Combining these measures may be a first step towards packages of

COVID-19 measures that better balance infection prevention and maintaining residents' well-being.
Registration : N/A
Tweetable abstract **:** Priority COVID-19 nursing home measures are isolation, testing, testing and isolation combinations, PPE use, preparations by outbreak teams, and visit regulations @wilcoachterberg

Keywords: COVID-19, Nursing homes, Infection prevention, Well-being, Measures, Policy making, Decision making

WHAT IS ALREADY KNOWN

- COVID-19 infection prevention measures can negatively impact nursing home residents' well-being.
- Society has been concerned that nursing home residents' autonomy has been overlooked in COVID-19 policymaking.
- Society has been concerned about the imbalance between infection prevention and residents' well-being. Nursing home staff, residents, and their families have been struggling to develop better balanced packages of COVID-19 measures.

WHAT THIS PAPER ADDS

- Resident representatives and staff were dissatisfied with their limited involvement in policy making during the first months of the COVID-19 pandemic, although they understood that decisions had to be made quickly.
- Priority measures during COVID-19 outbreaks in nursing homes include cohort isolation, testing, testing and isolation combinations, use of personal protective equipment, crisis management by COVID-19 outbreak teams, and nursing home visits regulations and instruction of visitors.
- There is overlap between priority measures for preventing infections and for maintaining residents' well-being during COVID-19 outbreaks in nursing homes: cohort isolation and combinations of testing and isolation were prioritized from both viewpoints.

BACKGROUND

Among nursing home residents, elevated risks of severe disease courses of COVID-19 and mortality were seen (1, 2). By May 2020, 37 to 66% of all COVID-19-related deaths in European countries had occurred in nursing homes and other long-term care facilities (1, 3). Inherent to the setting of nursing homes is close contact between people. Residents are often dependent on care that is provided by staff to multiple residents (2), and residents often share spaces, facilities, or activities (2, 4). COVID-19 therefore spreads easily among residents.

To protect vulnerable nursing home residents from COVID-19, many local and (inter)national guidelines and restrictions were applied during the first months of 2020, such as isolation measures, visiting bans or regulations, other distancing measures, testing, and use of personal protective equipment (5-9). Although these measures should prevent COVID-19 transmission, public concerns arose about the lack of attention for nursing home residents' well-being during spring and summer (10, 11). Research confirmed that social isolation and loneliness, depressive symptoms, grief, anxiety, and challenging behavior had increased among nursing home residents during the first year of the COVID-19 pandemic (12-15).

Researchers have suggested that infection prevention measures have to be weighed carefully against their potential harms (16) and person-centered care (17-19) in order to maintain residents' well-being. However, how these considerations are to be made in practice is not described (16, 17). Nursing home staff, residents, and residents' family members have also been struggling to find packages of measures that provide a better balance between infection prevention and maintaining residents' well-being (13, 20). Staff and residents' family feared for residents' safety and argued in favor of even stricter infection prevention measures, although they also found visitor restrictions difficult to cope with and campaigned for residents' freedom of movement (16, 21).

Another public concern was that nursing home residents' autonomy has been overlooked in COVID-19 policymaking (15, 22). It was argued that, especially due to their relatively short remaining life expectancy, many nursing home residents had died, or would die, under restrictive measures they had had no say in (23). However, the actual decision-making process in nursing homes and the involvement of residents regarding COVID-19 measures has hardly been studied.

In response to these two public concerns, the first aim of this study is to explore consensus among nursing home staff and resident representatives about measures they

found to be most important in contributing to preventing infections, and to maintaining residents' well-being during COVID-19 outbreaks in nursing homes. The second aim is to explore how the decision-making processes and the involvement of residents or their representatives regarding COVID-19 measures were organized and experienced in nursing homes.

METHODS

Design

This study has a mixed-methods design using the nominal group technique (NGT) (24-26). The NGT was slightly modified to an online procedure with a single rating phase. This consensus method has been used to identify COVID-19 measures that nursing home staff members and resident representatives give priority to. This study made use of participants and data from the MINUTES study (27).

Participants

Long-term care organizations that participated in the MINUTES study (27) were invited to participate. Since the focus of our study is on inpatient long-term care, these were all organizations with at least one nursing home or care home. An information letter was sent by email to the directors of these 41 long-term care organizations. Consent to study participation was received in reply to this email from 12 organizations. Next, the contact person of each participating organization distributed information letters to potential participants. Besides, we asked potential participants if they knew any colleagues who might be interested in receiving an information letter and considering participation in a next round of panels. When potential participants indicated interest in participating, we checked if there were not yet two participants from the same long-term care organization or with the same function registered for the next round of panels. Subsequently, we asked for their availability during the times of the scheduled online panel conversations and if they preferred to participate in a panel regarding infection prevention measures or about well-being measures.

The aim was to organize panels of 4 to 7 participants, to keep the online process manageable (24). To include diverse perspectives of stakeholders in nursing homes' policy making, we aimed to compose panels that consisted of multidisciplinary nursing home staff from various long-term care organizations, including managers or policy advisors; practitioners such as physicians, psychologists, or physiotherapists; nurses or care assistants; and resident representatives.

Setting

Shortly before the start of this study, in May 2020, nursing homes gradually started to reopen for visitors (28), and the Dutch 'first wave' of national excess mortality due to coronavirus infections was just over (29). However, nursing homes were still short of personal protective equipment (30). Right at the beginning of the study period, in June 2020, tests became available for Dutch citizens, including nursing home residents, with symptoms of COVID-19 (29). From September 2020 until June 2021, the indistinguishable second and third waves of coronavirus infections were ongoing (29). By the end of the study period in November 2020, there were no personal protective equipment shortages anymore, but restrictive measures, e.g., to limit group sizes, had been reintroduced at the national level (31). Vaccines were not yet available. Rounds of panels were organized in June, July, August and November 2020.

Procedures

The NGT is a structured group procedure for idea generation, problem solving, and priority setting that encourages equal input from all participants (26). A modified NGT was employed to define levels of agreement about priority COVID-19 measures among nursing home staff. Due to national COVID-19 restrictions, the study had to take place online. To limit the burden on the participants in a time of crisis, and because our aim was not to enforce consensus, but only to explore the existing level of consensus in this early stage of the pandemic, there was no secondary ranking or re-ranking, which is often the last phase of the NGT (24, 26). Multiple rounds of NGT panels from each viewpoint were conducted, until data saturation was reached in the topics of measures selected to be most important. The phases of the NGT are presented in **Table 1**.

Phase 1, the idea generation phase, consisted of a questionnaire via email one week before the panel meeting. The questionnaire contained questions about the most important measure during COVID-19 outbreaks from the viewpoint of either infection prevention or well-being, and about the decision-making process (**Table 1**). To activate participants' thoughts, a list of textual units from the MINUTES data (27) of the previous four weeks was attached to the questionnaire. As an example, **Supplement I** presents the attachment for the first panel about infection prevention measures.

In phase 2, the 1.5 to 2-hour panel conversations were conducted online via Zoom (32) and were guided by a facilitator, an assistant facilitator who also served as technical assistant before and during the conversation, and one person taking minutes (female researchers JG, LT, and SJ in alternating roles). The information letter contained technical instructions regarding Zoom, and shortly before and during the meeting, the assistant facilitator was available to provide participants with technical support. The conversa-

tions followed usual NGT steps: a round robin and a discussion. With a 10-minute break in between, these steps were performed for conversation part 1 regarding the selected measures and for part 2 regarding the decision-making process. The panel conversations were audio recorded.

Phase 3, rating of the measures discussed, was conducted by email one week after the panel conversation. Participants received a form with descriptions of the measures, including arguments and nuances that were mentioned during the conversation. They were asked to rate the importance and the urgency of each measure on a 5-point Likert scale. In addition, the form served as a member check (33). Descriptions of the measures were adapted if participants' comments indicated an inaccurate interpretation of the conversation.

Table 1. Procedures nominal group technique.

Phase	Format	Content/structure
1. Idea generation	Form by email	Open questions: 1. "What measure, taken in the nursing homes organizations you are affiliated with, do you think is most important to implement during a COVID-19 outbreak in nursing home organizations [to prevent infections /to maintain residents' well-being]?" 2. "Why this measure?" 3. "From whose perspective(s) was this measure decided? Was there participation/ consultation/ questioning of client(council)s?" 4. "Does this differ from the way policy is made in the normal situation? What do you think about that?" Attachment: list of textual units from the last four weeks of MINUTES data that described measures.
2. Panel conversation	Online via Zoom	Conversation part 1: measures (phase 1 questions 1 and 2) - step 1. Round robin: participants one by one explain their answers to open questions 1 and 2 - step 2. Discussion: participants ask each other clarifying questions and discuss their ideas Break Conversation part 2: decision making (phase 2 questions 3 and 4) - step 1. Round robin: participants one by one explain their answers to open questions 3 and 4 - step 2. Clarification and discussion
3. Rating	Form by email	5-point Likert scale questions: 1. "This measure is important for [infection prevention]/[the well-being of residents and their family] during COVID-19 outbreaks in the nursing home" 2. "Introducing this measure at the start of a COVID-19 outbreak in the nursing home is urgent, and cannot wait weeks" Comment field

Data analysis

The discussion elements of the panel conversations about important COVID-19 measures were transcribed verbatim. Between phases 2 and 3, the transcripts of conversation part 1, regarding COVID-19 measures, were analyzed using content analysis (25, 34) and converted into the measure descriptions on the rating forms (LT, checked by JG and SJ). After phase 3, the rated measures were classified under the eight main topics that were identified in the MINUTES study as topics of discussion in COVID-19 outbreak teams: crisis management, isolation of residents, personal protective equipment and hygiene, staff, residents' well-being, visitor policies, testing, and vaccination (27) (LT, checked by HS and MC). This classification facilitated comparison between the measures prioritized by the well-being panel and by the infection prevention panel. Measures were considered to be prioritized in consensus if they were ranked as (very) important (4 or 5 points) and (very) urgent (4 or 5 points) by all panel members. The transcripts of part 2 of the panel conversations, regarding decision making, were inductively thematically analyzed (LT, reviewed and discussed with HS) (34).

Ethics

The study was exempt from the Medical Research Involving Human Subjects Act by the Medical Ethics Committee Leiden The Hague Delft (protocol number N20.093). The directors of the long-term care organizations and all panel participants provided written informed consent. The study was announced on the Long-Term Care response to COVID-19 website on March 10, 2021 (35).

RESULTS

Participants

Four rounds of panels on infection prevention and on well-being were performed. After for rounds, data saturation was reached in all topics except crisis management. This topic was assumed to indicated that by November, nursing homes no longer experienced the pandemic as a crisis but reflected on and prepared for future crisis situations. In total, 19 participants participated in the infection prevention panels, and 16 in the well-being panels. Each panel consisted of 3 to 6 participants. Their median ages were 55 (range 30 – 73) and 50 (range 21 – 73) years, 68% and 56% were female, and their median years of experience in their positions were 8.0 (3.0-24.0) and 5.5 (1.6-7.8) years, respectively. Participants included care assistants, elderly care physicians, managers, nurses, policy advisors, psychologists, resident representatives, and a spiritual counselor (**Table 2**). There were no panels with more than one pair of participants from the same function or more than one pair of two participants from the same long-term care organization. The

resident representatives were all members of nursing home client councils and current or former family caregivers of nursing home residents.

Table 2. Participant characteristics.

	Infection prevention panels (n=19)	Maintaining well-being panels (n=16)
Sex		
Female	68.4% (n=13)	56.3% (n=9)
Age (Median (range))	55 (30 – 73)	50 (21 – 73)
Function		
Care assistant*	5.3% (n=1)	6.3% (n=1)
Elderly care physician	10.5% (n=2)	N/A
Manager**	21.1% (n=4)	31.3% (n=5)
Nurse	15.8% (n=3)	18.8% (n=3)
Policy advisor	26.3% (n=5)	6.3% (n=1)
Psychologist	N/A	12.5% (n=2)
Resident representative	15.8% (n=3)	25.0% (n=4)
Spiritual counselor	5.3% (n=1)	N/A
Years in position (Median (IQR))	8.0 (3.0 – 24.0)	5.5 (1.6 – 7.8)

*care assistants were a 'carer' and an 'activity supervisor', **one manager was also chair of the pre-pandemic infection prevention committee

Infection prevention measures

The 19 participants in the panels about infection prevention selected and discussed 16 different measures. These 16 measures were on the topics of isolation, testing, testing and isolation combinations, personal protective equipment, hygiene, visiting measures, and crisis management. Of these 16 measures, 9 were prioritized as being (very) important and (very) urgent in nursing homes during COVID-19 outbreaks. These 9 priorities are described below (**Table 3**).

Of the 9 prioritized measures, 3 concerned the topic of isolation. These isolation measures varied from cohort isolation of wards with infected residents and entry restricted to a limited number of staff members with personal protective equipment (June); transfer of infected residents who cannot be isolated on their ward to an organizational or regional COVID-19 unit (July); and isolation of residents with (suspected) COVID-19 who are cognitively able to comply with this measure in their single room (August). Panel members argued that transfer and isolation in a COVID-19 unit would stimulate

Table 3. Prioritization of measures preventing infections during COVID-19 outbreaks in nursing homes (nominal group technique phase 3).

Measure	Panel (month)	Importance scores						Urgency scores					
		5	4	3	2	1	*missing*	5	4	3	2	1	*missing*
Isolation													
Isolate wards with infected residents as cohorts and restrict entry to limited number of staff members with PPE*	**Jun**		**2**				***2***	**2**					***2***
Transfer infected residents who cannot be isolated on own ward to a COVID-19 unit	**Jul**	**2**	**3**					**2**	**3**				
Isolate residents with (suspected) COVID-19 who are able to comply with isolation measures in a single room	**Aug**	**3**	**1**				***1***	**3**	**1**				***1***
Transfer residents with (suspected) COVID-19 not able to comply with isolation measures to a COVID-19 unit	Aug		2	2			*1*		3	1			*1*
Tailor isolation measures for specific locations, wards, and for residents by their physician	Aug	2		2			*1*	1	2	1			*1*
Testing													
Test residents and staff with (minor) symptoms and isolate them in the case of a positive result	**Jul**	**4**	**1**					**3**	**2**				
Test staff and residents within the care organization itself if national testing resources are scarce	**Nov**	**2**	**3**					**2**	**2**				***1***
Testing and isolation combinations													
Test and transfer residents suspected of COVID-19 to a COVID-19 unit with experienced staff	**Jun**	**1**	**1**				***2***	**1**	**1**				***2***
Test and isolate residents who are (possibly) infected until a negative test result is obtained	**Nov**	**4**	**1**					**4**	**1**				
PPE*													
Use personal PPE* around (suspected) infected residents	**Jul**	**4**	**1**					**4**	**1**				
Use of mouth-nose masks as a precaution by all staff members who enter wards with residents	Nov	3	1	1				4		1			
Crisis management													
Preparation for outbreaks by a COVID-19 outbreak team	**Nov**	**3**	**2**					**3**	**2**				

Measure	Panel (month)	Importance scores						Urgency scores					
		5	4	3	2	1	*missing*	5	4	3	2	1	*missing*
Hygiene													
Raise staff's awareness of general hygiene, which includes work clothes, PPE*, jewelry, and hand hygiene	Jun	2					*2*	1		1			*2*
Keep hygiene and infection prevention policies up to date and share the content with staff	Jul	3	1	1				2	1	2			
Visiting policies													
Ban all visitors other than staff, including residents' families, volunteers, and suppliers	Jun	1		1			*2*	1			1		*2*
Decentralize policy making about strict visiting instructions and regulating the flow of visitors	Aug	2	1	1			*1*	2	2				*1*

*Note: measures in bold are prioritized in consensus. *PPE: personal protective equipment*

a regionally uniform policy, centralize experiential knowledge on caring for COVID-19 patients, and centralize usage and therefore save personal protective equipment. Isolation in single rooms would prevent transfer of residents to a COVID-19 unit with staff who are not familiar with their normal behavior. Cohort isolation was argued to prevent transfer so residents can stay in their familiar environment as well as prevent isolation in single rooms so residents retain some freedom of movement.

Four measures were prioritized in the topics of testing (n = 2), and testing and isolation combinations (n = 2). The testing measures were, first, immediate testing of residents and staff in the event of (minor) symptoms, and isolation in case of a positive test result (July). Second, testing of staff and residents should be performed within the care organization itself if national testing resources are scarce or processes are slow (November). The prioritized combinations of testing and isolation were testing and transferring residents suspected of COVID-19 to a COVID-19 unit with experienced staff, especially when test results are not quickly available (June); and, in nursing homes where the building structure makes it difficult to prevent transmission of the virus, testing and isolating residents who are (possibly) infected until a negative test result is obtained (November). Both panels argued that testing can shorten the period during which isolation measures are needed.

Measures prioritized in other topics (n = 2) were, first, the use of personal protective equipment around (suspected) infected residents (July). This measure was argued to reduce unrest among staff. Second, having an organizational COVID-19 outbreak teams to prepare for outbreaks was prioritized (November). This was aimed at reducing fear and work overload of staff.

Measures to maintain residents' well-being

The 16 participants in the well-being panels selected and discussed 14 different measures. These 14 measures were on the topics of visitor policies, isolation, testing and isolation combinations, crisis management, and activities for residents. Of these 14 measures, 8 were prioritized as being (very) important and (very) urgent to maintain the well-being of nursing home residents during COVID-19 outbreaks by all panel members. These 8 priorities are described below (**Table 4**).

Of the 8 prioritized measures, 5 concerned the topic of visitor policies. One panel prioritized not permitting visitors to visit residents or wards with positive test results, but allowing visitors who wear mouth masks to visit residents who are suspected of having COVID-19 (August). Two panels prioritized exceptions to visitor bans for terminal residents and other distressing cases (June) and for residents in the phase of dying

Table 4. Prioritization of measures maintaining residents' well-being during COVID-19 outbreaks in nursing homes (nominal group technique phase 3).

measure	Panel (month)	Importance scores						Urgency scores					
		5	4	3	2	1	*missing*	5	4	3	2	1	*missing*
Visiting policies													
Lift visitor bans in the case of terminal residents and any other distressing cases	**Jun**	**4**						**4**					
Allow residents in the dying phase to receive 2 or 3 visitors daily with PPE*	**Jul**	**2**	**1**					**2**	**1**				
Register visits and accompany visitors to the residents' rooms	**Aug**	**1**	**3**					**3**	**1**				
Do not permit visitors to visit residents or wards that have tested positive	**Aug**	**2**	**2**					**4**					
Limit the daily number of visitors to 2 or 3 of the residents' choice during COVID-19 outbreaks	**Nov**	**3**	**2**					**3**	**2**				
Ban visitors or allow only regulated visiting, tailored to residents' wishes	Jun	1	1	2				1		1	2		
Facilitate 'visiting windows' where family and residents can see and (video) call each other	Jun	1	2	1				2	1	1			
Isolation													
Isolate ward with residents who are (suspected of) having COVID-19 as a cohort	**Jul**	**2**	**1**					**2**	**1**				
Tailor cohort isolation to the smallest possible units or wards around a COVID-19 outbreak	**Aug**	**3**	**1**					**4**					
Cohort wards and compartment staff to cohorts to allow living room activities to continue within cohorts	Jun	1	3					1	2	1			
Testing and isolation combination													
Test and isolate residents with suspected COVID-19 in their rooms; and in case of positive test results, isolation the entire ward as a cohort	**Jul**	**3**						**3**					
Crisis management													
Appoint a crisis manager or crisis team	Nov	1	2	1	1			2	1	2			
Organize evaluation conversations on COVID-19 measures	Nov	3	2					2		3			
Well-being activities													
Continue indoor and outdoor activities for residents from the same wards	Jul	2	1					1	1	1			

*Note: measures in bold are prioritized in consensus. *PPE: personal protective equipment*

(July). This last panel wanted to allow a maximum of 2 or 3 visitors daily with personal protective equipment. Two panels furthermore prioritized registration of visits and accompanying visitors to the residents' rooms (August), a maximum of 2 or 3 visitors of the residents' choice per day per resident during COVID-19 outbreaks, and additional clear restrictions such as location of visits, mandatory mouth masks, and registration of visits (November). These panel members argued that regulation of visits has less impact on residents' and their family members' daily lives and intimacy and on the workload for staff, than visitor bans. In addition, all visiting measures other than visitor bans were argued to be important to maintain residents' autonomy or privacy.

The other three prioritized measures concerned the topics of isolation and testing and isolation combination. These are overlapping with measures prioritized by the panels about infection prevention. The figure in **Supplement II** illustrates this overlap. Cohort isolation should be applied to wards with (suspected) infected residents (July), and tailored to the smallest possible units or wards around a COVID-19 outbreak (August). Participants argued that cohort isolation to the smallest possible unit or ward would keep the impact on residents, their family, and staff to a minimum (August), and keep other wards within the building accessible for visitors (July). In addition, testing and isolating residents with suspected COVID-19 in their room (droplet isolation) was prioritized. A positive test result would require transition from room isolation to cohort isolation of the ward (July).

Decision making

Most participants were aware of how decisions regarding COVID-19 measures were made within their organization. They explained that the COVID-19 outbreak teams made decisions more quickly and more top-down than usual, often implementing national COVID-19 policies (**Supplement III: quote 1 (Q1))**. However, they did not always know of whom the outbreak teams consisted. Resident representatives were often not involved at all, and were merely informed of COVID-19 policies. Often they only remained involved in the topic of visitor policies **(Q2)**. Barriers to their involvement in the decision-making included not being able to get together on location, to meet with staff, and COVID-19 outbreak teams meeting ad hoc (**Q3**). One panel discussed the possibility of including a resident representative in a COVID-19 outbreak team, but this panel's participants were divided about this idea.

Several staff members indicated feeling they were not heard by the COVID-19 outbreak team (**Q4).** Some staff members explained that they were informed of decisions about COVID-19 measures, but that their questions, or questions they received from residents, family members, and other staff remained unanswered.

While resident representatives and staff expressed dissatisfaction and irritation about their decreased involvement (**Q5**), they also indicated understanding the accelerated decision-making process during the first months of the pandemic (**Q6**). The panels of August and November indicated that staff and client councils were increasingly involved in COVID-19 policy making, and that staff was given more freedom in applying policies (**Q7**).

According to one participant, the decision making process did not differ much from before the pandemic, because it was usual that deviations from 'normal' care were discussed with the manager or physician who were now part of the COVID-19 outbreak team.

DISCUSSION

This study examined a set of COVID-19 measures nursing home staff and resident representatives deemed most important and urgent to prevent infections and maintain residents' well-being during COVID-19 outbreaks in nursing homes. They prioritized cohort isolation and testing and isolation combinations to both prevent infections and maintain residents' well-being. In addition, to prevent infections, more isolation measures, testing measures, use of personal protective equipment around (suspected) infected residents, and preparation for outbreaks by COVID-19 outbreak teams were prioritized; and to maintain residents' well-being, exceptions to visitor bans and several visitor policies were prioritized. These measures combined may be a first step towards packages of COVID-19 measures that better balance infection prevention and maintaining well-being. Resident representatives and staff were dissatisfied with their reduced involvement in policy making during the COVID-19 pandemic, although they understood that decisions had to be made quickly. These prioritized sets of measures are a first step towards packages of COVID-19 measures that better balance infection prevention and maintaining residents' well-being.

This is the first study to prioritize COVID-19 measures in terms of importance and urgency during outbreaks in nursing homes to both prevent infections and maintain residents' well-being. In line with our findings, priority research areas regarding infection prevention that have been designated academic authors and specialist societies include testing and vaccination, and use of personal protective equipment; and also well-being priorities including consequences of COVID-19 for physical, cognitive and psychological health, and the impact of social distancing and lock-down policies (36). Besides, two literature reviews described COVID-19 best practices and potentially effective measures

that are mainly in the topics that our study rated to be important, including (cohort) isolation, testing, combining testing and isolation, use of personal protective equipment, hygiene reinforcement, visiting policies, and crisis management (18, 37). In addition to our results, these reviews also described ventilation, digital health applications such as real-time outbreak monitoring, workforce management (18), and person-centered care (37) to be important. Although person-centered care may refer to residents' well-being, these reviews included mostly studies that were only focused on infection prevention, Moreover, many of the studies included in these reviews did not include the perspective of nursing home staff, residents, or resident representatives.

In our study testing and isolation combinations were also prioritized by the well-being panels, although intuitively these may be only infection prevention measures. A plausible explanation is that participants were inclined to select infection prevention measures because they experienced mainly this type of measures in practice during the first months of the pandemic. The well-being measures reflect that relaxation of infection prevention measures benefits residents' well-being. Besides, this might also be explained by the CDC definition of well-being, which besides mental, social, and autonomy components, also includes a physical component (38). Nursing home staff might indeed have regarded infection prevention as part of maintaining physical health and an integral part of well-being. Future research could reveal if the focus regarding well-being has changed after the acute crisis passed.

Our study showed that the autonomy of nursing home residents should be maintained during COVID-19 outbreaks. According to literature, the norm is to involve them or their representatives in care decisions and to deliver person-centered care (13, 39). Dutch care organizations are obliged to have a client council that is informed about, can give advice, and can consent to organizational policy decisions (40). Despite these norms and obligations, internationally involvement of nursing home residents in care and policy decisions remains difficult (41). With regard to COVID-19 measures, researchers have also advised tailor-made measures and the involvement of residents, family, and staff (5, 14, 17, 19). However, our study shows that resident representatives and nursing home staff were less involved in policy making during the first months of the COVID-19 pandemic than before. In fact, according to another Dutch study opinions of staff and resident representatives about who was responsible for policy making even became divided (42). This may be due to hierarchical (18) centralized quick policy making during the first months of the pandemic (22). However, our results showed that by November 2020 there was more room for involvement in the decision-making processes within nursing homes. It has been suggested that, ultimately, these first months of the CO-

VID-19 pandemic may have been a catalyst for a bottom-up urging to better embed involvement in the nursing home sector (23).

Strengths

A first strength of this study is the bottom-up perspective. Our participants represented disciplines that ideally take part in nursing home policy making, ranging from nursing home managers to care assistants, and resident representatives. It is crucial that they support the policy decisions made (23, 43). Second, this study is unique in its prioritization of COVID-19 measures. We made use of a modified NGT to quickly generate results that are easily translatable to nursing home policies and practice. Many different COVID-19 measures have been recommended and implemented, and it has been difficult to select a balanced package of COVID-19 measures. The NGT has much been used to explore priorities and for policy development about other healthcare issues (24, 25). Third, performing this NGT study online made it possible to collect data about COVID-19 measures during the national COVID-19 restrictions. In addition, by performing the study online, participants from across the country were able to participate without traveling (44, 45).

Limitations

Limitations of this study were, first, the small numbers of participants per panel. Still, after four rounds of panels, data saturation was reached. Second, this study was performed during the first year of the COVID-19 pandemic, when vaccines were not available yet. Recent literature stresses the importance of vaccination. Vaccination might have changed the urgency of other measures to prevent infections and maintain well-being in nursing homes. Future research should explore this renewed balance. Third, effectiveness of measures in preventing infections or maintaining well-being remains unknown. In the first phase of the COVID-19 pandemic, effectiveness studies would have been too time consuming, and it would have been ethically irresponsible to withhold potentially effective measures from non-vaccinated NH. In this study, participants' arguments in favor of the prioritized measures included perceived effectiveness, but also feasibility in practice and ethics. Thus, the measures prioritized should be the first focus in future effectiveness studies. Fourth, although formal resident representatives from client councils participated in this study, no nursing home residents participated. All of the client representatives willing to participate were current or former family caregivers. They may have been more familiar with digital communication than most residents. As described in the study background, family members feared for residents' safety and may therefore have selected more infection prevention measures to maintain well-being than residents themselves would do. Future research should also explore which measures have priority from the perspective of residents themselves.

CONCLUSIONS

In conclusion, this study has laid bare that long-term care organizations and the Dutch government were not well-prepared and had no policy in place for a highly infectious disease epidemic in the sector. However, Dutch long-term care organizations were flexible and reactive. During future times of crisis when decisions are made more quickly than usual, staff and residents or their representatives should be better informed about the decision making processes, more involved in decisions, and have more opportunities to ask questions than they had during the first months of the COVID-19 pandemic. Long-term care organizations may draw up a crisis communication and involvement protocol that includes sharing weekly updates with staff. In addition, staff should be given room to tailor-make COVID-19 measures. Priority measures during COVID-19 outbreaks in nursing homes to prevent infections and to maintain residents' well-being partly overlap, and include cohort isolation and other types of isolation, testing measures, testing and isolation combinations, use of personal protective equipment around (suspected) infected residents, crisis management by COVID-19 outbreak teams, and regulation of visits and instructing visitors. Despite public commotion regarding the perceived imbalance between infection prevention and maintaining well-being during the first months of the pandemic, the measures prioritized to maintain residents' well-being seem to mostly reflect gradual relaxation of infection prevention measures. This may be caused by the fact that mainly this type of measures were taken and experienced by the study participants. Future research may reveal whether after the acute crisis situation other topics also have gained priority to maintain residents' well-being during infectious disease outbreaks. These prioritized sets of measures are a first step towards packages of COVID-19 measures that can overcome the perceived imbalance between infection prevention and maintaining residents' well-being. The next step should be to let nursing home staff and residents jointly weigh the prioritized measures. For now, the study results can be translated to nursing home policies and can be used to provide focus to crisis management in future outbreaks of highly infectious or unknown respiratory viral diseases in nursing homes. When doing so, with each measure the effect on residents' well-being should be considered.

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Declaration of Competing Interest
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REFERENCES

1. Comas-Herrera A, Marczak J, Byrd W, Lorenz-Dant K, Pharoah D, LTCcovid-contributors, et al. Mortality associated with COVID-19 in care homes: international evidence. International Long Term Care Policy Network; 2020 Oct 14.
2. Ayalon L, Zisberg A, Cohn-Schwartz E, Cohen-Mansfield J, Perel-Levin S, Siegal EBA. Long-term care settings in the times of COVID-19: challenges and future directions. International Psychogeriatrics. 2020;32(10):1239-43.
3. Team EPHE, Danis K, Fonteneau L, Georges S, Daniau C, Bernard-Stoecklin S, et al. High impact of COVID-19 in long-term care facilities, suggestion for monitoring in the EU/EEA, May 2020. Euro Surveill. 2020;25(22).
4. Gardner W, States D, Bagley N. The Coronavirus and the Risks to the Elderly in Long-Term Care. J Aging Soc Policy. 2020;32(4-5):310-5.
5. van Tol LS, Smaling HJA, Meester W, Janus SIM, Zuidema SU, de Waal MWM, et al. Distancing Measures and Challenges Discussed by COVID-19 Outbreak Teams of Dutch Nursing Homes: The COVID-19 MINUTES Study. Int J Environ Res Public Health. 2022;19(11).
6. CDC. Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nusring Homes. Centers for Disease Control and Prevention; 2021 Apr 19.
7. ECDC. Infection prevention and control and preparedness for COVID-19 in healthcare settings - Sixth update. European Centre for Disease Prevention and Control; 2021 Feb 9.
8. Infection prevention and control guidance for long-term care facilities in the context of COVID-19. World Health Organization; 2021.
9. Comas-Herrera A AE, Lorenz-Dant K. International examples of measures to prevent and manage COVID-19 outbreaks in residential care and nursing home settings. LTCcovid.org: International Long-Term Care Policy Network, LTCcovid.org; 2020 May 2.
10. BBC. Coronavirus and care homes: The pensioners suffering through isolation. BBC news. 2020 Oct 18.
11. Chason R. A daughter's choice: Her mom didn't have covid-19. But isolation seemed to be killing her. The Washington Post. 2020 Aug 21.
12. Benzinger P, Kuru S, Keilhauer A, Hoch J, Prestel P, Bauer JM, et al. Psychosocial effects of the pandemic on staff and residents of nursing homes as well as their relatives-A systematic review. Z Gerontol Geriatr. 2021;54(2):141-5.
13. Leontjevas R, Knippenberg IAH, Smalbrugge M, Plouvier AOA, Teunisse S, Bakker C, et al. Challenging behavior of nursing home residents during COVID-19 measures in the Netherlands. Aging & Mental Health. 2021;25(7):1314-9.
14. Van der Roest HG, Prins M, van der Velden C, Steinmetz S, Stolte E, van Tilburg TG, et al. The Impact of COVID-19 Measures on Well-Being of Older Long-Term Care Facility Residents in the Netherlands. J Am Med Dir Assoc. 2020;21(11):1569-70.
15. Low LF, Hinsliff-Smith K, Sinha SK, Stall NM, Verbeek H, Siette J, et al. Safe Visiting is Essential for Nursing Home Residents During the COVID-19 Pandemic: An International Perspective. J Am Med Dir Assoc. 2021;22(5):977-8.
16. Gordon AL, Goodman C, Achterberg W, Barker RO, Burns E, Hanratty B, et al. Commentary: COVID in care homes-challenges and dilemmas in healthcare delivery. Age Ageing. 2020;49(5):701-5.
17. Dichter MN, Sander M, Seismann-Petersen S, Kopke S. COVID-19: it is time to balance infection management and person-centered care to maintain mental health of people living in German nursing homes. International Psychogeriatrics. 2020;32(10):1157-60.

18. Dykgraaf SH, Matenge S, Desborough J, Sturgiss E, Dut G, Roberts L, et al. Protecting Nursing Homes and Long-Term Care Facilities From COVID-19: A Rapid Review of International Evidence. J Am Med Dir Assoc. 2021;22(10):1969-88.
19. Dohmen MDW, van den Eijnde C, Thielman CLE, Lindenberg J, Huijg JM, Abma TA. Good Care during COVID-19: A Narrative Approach to Care Home Staff's Experiences of the Pandemic. Int J Environ Res Public Health. 2022;19(4).
20. Gerritsen DLL, R.; Prins, M.; Van der Roest, H. De gevolgen van de COVID-19 maatregelen voor het welbevinden van bewoners van instellingen voor langdurige zorg. Tijdschrift voor Gerontologie en Geriatrie. 2022 3 March.
21. Smaling HJA, Tilburgs B, Achterberg WP, Visser M. The Impact of Social Distancing Due to the COVID-19 Pandemic on People with Dementia, Family Carers and Healthcare Professionals: A Qualitative Study. Int J Env Res Pub He. 2022;19(1).
22. Gordon AL, Spilsbury K, Achterberg WP, Adams R, Jones L, Goodman C. From Warkworth House to the 21st century care homes: progress marked by persistent challenges. Age Ageing. 2022;51(7).
23. Chu CH, Donato-Woodger S, Dainton CJ. Competing crises: COVID-19 countermeasures and social isolation among older adults in long-term care. J Adv Nurs. 2020;76(10):2456-9.
24. McMillan SS, Kelly F, Sav A, Kendall E, King MA, Whitty JA, et al. Using the Nominal Group Technique: how to analyse across multiple groups. Health Serv Outcome. 2014;14(3):92-108.
25. Potter M, Gordon S, Hamer P. The Nominal Group Technique: A useful consensus methodology in physiotherapy research. NZ Journal of Physiotherapy. 2004;32(2):70-5.
26. Gallagher M, Hares T, Spencer J, Bradshaw C, Webb I. The Nominal Group Technique - a Research Tool for General-Practice. Family Practice. 1993;10(1):76-81.
27. van Tol LS, Smaling HJA, Groothuijse JM, Doornebosch AJ, Janus SIM, Zuidema SU, et al. COVID-19 management in nursing homes by outbreak teams (MINUTES) - study description and data characteristics: a qualitative study. BMJ Open. 2021;11(11):e053235.
28. Sizoo EM, Monnier AA, Bloemen M, Hertogh CMPM, Smalbrugge M. Dilemmas With Restrictive Visiting Policies in Dutch Nursing Homes During the COVID-19 Pandemic: A Qualitative Analysis of an Open-Ended Questionnaire With Elderly Care Physicians. J Am Med Dir Assoc. 2020;21(12):1774-+.
29. CBS. The year of coronavirus www.cbs.nl: CBS; 2020. Available from: https://www.cbs.nl/en-gb/news/2020/53/the-year-of-coronavirus.
30. Marijnissen J, Dijkhoff, Segers, Asscher, Klaver, Heerma P. Nr. 329 Motie van het lid Marijnissen C.S. In: Infectieziektenbestrijding, editor.: Tweede Kamer der Staten-Generaal; 2021.
31. RIVM. Tijdlijn van maatregelen voor bestrijding COVID-19: Rijksinstituut voor Volksgezondheids en Milieu; 2020. Available from: https://www.rivm.nl/gedragsonderzoek/tijdlijn-maatregelen-covid.
32. Zoom. Zoom Video Communications. zoom.us; 2022.
33. Varpio L AR, Monrouxe LV, O'Brien BC, Rees CH. Shedding the cobra effect: problematising thematic emergence, triangulation, saturation and member checking. Medical Education. 2016;51:40-50.
34. Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. Nurs Health Sci. 2013;15(3):398-405.
35. van Tol LS. Prioritizing measures taken: Covid-19 Management In NUrsing homes by outbreak TEamS (MINUTES) follow-up study (Part 2) Research projects: LTCcovid.org; 2021 [updated 10 March 2021; cited 2022 1 November]. Available from: https://ltccovid.org/project/prioritizing-

measures-taken-covid-19-management-in-nursing-homes-by-outbreak-teams-minutes-follow-up-study-part-2/.

36. Richardson SJ, Carroll CB, Close J, Gordon AL, O'Brien J, Quinn TJ, et al. Research with older people in a world with COVID-19: identification of current and future priorities, challenges and opportunities. Age Ageing. 2020;49(6):901-6.
37. Martinez-Paya M, Carrillo I, Guilabert M. Lessons Learned from the COVID-19 Pandemic in Nursing Homes: A Systematic Review. Int J Environ Res Public Health. 2022;19(24).
38. CDC. Well-Being Concepts: Centers for Disease Control and Prevention, Division of Population Health;2018. Available from: https://www.cdc.gov/hrqol/wellbeing.htm#eight.
39. Roach P, Zwiers A, Cox E, Fischer K, Charlton A, Josephson CB, et al. Understanding the impact of the COVID-19 pandemic on well-being and virtual care for people living with dementia and care partners living in the community. Dementia (London). 2021;20(6):2007-23.
40. Wet medezeggenschap cliënten zorginstellingen 2018 [Participation in Client Care Institutions Act 2018].
41. Lynch B, Ryan AA, O'Neill M, Penney S. The factors that influence care home residents' and families' engagement with decision-making about their care and support: an integrative review of the literature. BMC Geriatr. 2022;22(1):873.
42. Visser MT, B.; Achterberg, W.P.; Smaling, H. Sociaal contactbeperkende maatregelen en dementie. Suggesties van mantelzorgers en zorgprofessionals voor de zorg. Tijdschrift voor Ouderengeneeskunde. 2022(3).
43. ActiZ. Handreiking bezoek en sociaal contact. Uitbraken van virussen & ziekteverwekkende micro-organismen in verpleeghuizen. ActiZ; 2022 May.
44. Willemsen RF, Aardoom JJ, Chavannes NH, Versluis A. Online synchronous focus group interviews: Practical considerations. Qual Res. 2022.
45. Mason S, Ling J, Mosoiu D, Arantzamendi M, Tserkezoglou AJ, Predoiu O, et al. Undertaking Research Using Online Nominal Group Technique: Lessons from an International Study (RESPACC). J Palliat Med. 2021;24(12):1867-71.

SUPPLEMENT I: LIST OF TEXTUAL UNITS FROM THE MINUTES DATA - ATTACHMENT TO THE IDEA GENERATION QUESTIONNAIRE OF JUNE'S PANEL ON INFECTION PREVENTION

Segregation and isolation of clients

- Separate locations such as care hotels are set up as COVID centers
- Anteroom area available to isolate room and for donning personal protective equipment (PPE).
- Discharge procedure from COVID ward has been established. Definition no longer infectious: when client is symptom-free for 24 hours, at least 14 days after the start of the symptoms, and when client has had droplet isolation for 7 days after the 24 hours symptoms-free.
- Restaurant may reopen 14 days after positive test of last client.
- Care agreement stops when a client goes home with a family caregiver.
- From multiple- to single-bed rooms on [ward X].
- Signage (for one-way routes) is made compulsory. Where too narrow for one direction, (expensive) traffic lights can be used.
- Local residents with physical therapy inside a location are only allowed in if there is a separate entrance and exit.
- Stop on internal transfers and new admissions.
- 2 infections on 1 ward considered as whole ward infected, admissions freeze.
- Chairs with upholstery and cabinets with knickknacks removed from Covid cohorts
- Locations with a terrace on the ground floor will be cordoned off with tape.
- Upon return after leaving location, client must be quarantined for 2 weeks.
- Rehabilitation wards of 7 locations become COVID-cohorts.
- Moving clients who have tested positive is avoided.
- Isolate suspected/infected client in own room. If not feasible (due to behavioural problems/client unable to follow instructions/serious aggression/inappropriate accommodation), client is transferred to cohort ward.
- Residents in individual isolation can be transferred to Covid-Cohort by mutual agreement.
- Negatively tested clients are also quarantined for 24 hours as a precaution.
- If a resident with an urge to wander and suspected corona-virus infection, the doctor decides how best to isolate the resident. In practice, this will involve confinement to the room or sedation.
- After three days symptom-free and at least 8 days after diagnosis by test, the isolation can be lifted. In case of doubt, a second test (at least 24 hours apart) can be performed.
- Admissions freeze infected location.
- New admissions who were not tested in hospital are tested prior to admission.
- PG (psychogeriatrische) cliënten met loopdrang zijn moeilijk instrueerbaar (moeilijk in quarantaine te houden) en worden daarom niet opgenomen.
- Housekeeping will not clean rooms of positive clients. This is done by the care workers themselves.

New admissions

- After a death, a bed in the nursing home can be released for a new resident. If it is a bed in a covid-cohort, only a new resident with (suspected) covid can be admitted.
- When new clients move in, they do not have to be quarantined for 14 days, unless they have symptoms.

- Upon admission, 2 weeks isolation policy (from hospital, care institution or home situation), temperature taken 2x a day, resident stays in own room.
- Process of moving in clients is discussed in broad outline and adjusted where necessary (e.g., guided tour via video calls, professional removal company moving personal belongings).

Hygiene

- Before bedding is taken away to be washed by an external party, the bedding must first be packed airtight for 24 hours.
- Place hand disinfection columns for visitors.
- In case of infection, we clean contacts with alcohol/disinfectant. Other areas with microfibre and water.
- Cleaners pay extra attention to contact points like (door)handles and handrails.
- Keyboards, pagers, etc. may be disinfected with 70% alcohol.
- Cleaner cleans isolated areas last, then goes home.

Personal Protective Equipment (PPE)

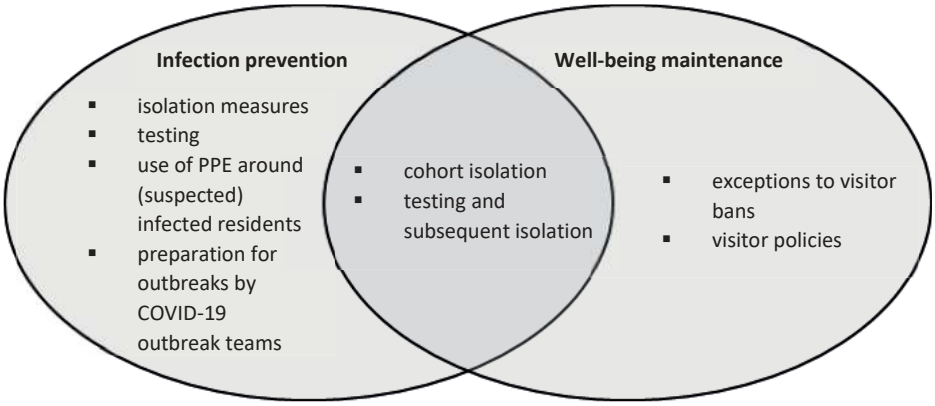
- To accept client from the hospital there must be sufficient PPE, either provided by hospital or from our own stock.
- For new admissions and new clients in home care, employees use PPE the first 7 days
- For new applications for terminal overnight care, the organization will accept the client only if supply of PPE is sufficient.
- Employees who have been in contact with a confirmed covid patient are requested to wear a surgical mouth-nose mask and gloves, even if they themselves have no symptoms (yet), to protect other clients.
- Person who accompanies client for hospital visit is required to wear a face mask.
- Instruct personnel about face masks.
- Collect face masks and aprons for reuse.
- Aprons can be worn for up to one shift, including when the apron keeps the isolation gown visibly clean. If the isolation gown gets wet or dirty during a shift: change.
- Staff will always use face masks when a client is quarantined.
- Only face mask in case client has symptoms.
- Employees wear masks in the covid-cohort and on the covid-unit.
- In case of urgent family visits to client, the organization provides PPE to prevent outside infections entering the site.
- Employees without symptoms do not wear face masks, that is not necessary.
- Due to apron shortage only 3 care moments per day in individual isolation.

Other

- Leave contaminated items in a deceased resident's room for 72 hours. After that, do not move clean items across dirty hallway.
- Do not use one lift, only for 'contaminated' items.
- No mouth-to-mouth resuscitation, chest compression only.
- Clients only go to the hospital for check-up appointments if the specialist feels it is necessary. Then we must facilitate this. Otherwise, appointment by telephone or rescheduled.
- Day care: option only for extreme cases, recommendation max. 3 persons.
- All care and treatment only if really necessary. Hairdresser/pedicure not yet. Use face masks.
- Regular treatments in hospitals are started again. Clients may, only when medically necessary, go to a hospital treatment together with a carer if both are free of symptoms and the carer has not had unprotected contact with a person infected with covid.

- To protect resident from outside influences, they cannot go to partner's funeral 'outside the house', unless quarantine is possible upon return.
- Test caregivers with mild symptoms who have client contact.
- Expand testing opportunities to all employees who have symptoms.

SUPPLEMENT II: OVERLAP BETWEEN MEASURES PRIORITIZED TO PREVENT INFECTIONS AMONG RESIDENTS AND MEASURES PRIORITIZED TO MAINTAIN RESIDENTS' WELL-BEING DURING COVID-19 OUTBREAKS IN NURSING HOMES



SUPPLEMENT III: QUOTES FROM PART 2 OF THE PANEL CONVERSATIONS REGARDING DECISION MAKING

Quote 1: *"the measures taken were rather directive, based on national decisions. [..] The client council was informed of the measures and was not consulted beforehand."* (resident representative A; August 2020, well-being panel)

Quote 2:"*In my opinion, the early communication was more in the form of announcements, not of consultation. Except when the visiting arrangements were expanded. In the beginning, the visitor policies were also just an order from above."* (manager; July 2020, infection prevention panel)

Quote 3: *"If advice needs to be given quickly, it becomes difficult to ask your local client council for their opinion. [..] At that time the client council was not allowed to join the outbreak team. But the discussions often take place ad hoc and then they can't attend."* (resident representative B; November 2020, infection prevention panel)

Quote 4: *"Nurses are also not very often included in decision-making. Comments don't make it past location managers who are very busy, and so they don't end up in the right place."* (nurse; June 2020, well-being panel)

Quote 5: *"In the beginning they [COVID-19 outbreak team] were very strict about those are government rules. [..] It's different now, but the strictness of that time caused a lot of irritation and complaints."* (psychologist A; August 2020, well-being panel)

Quote 6: *"I get the speed, but I also understand that people feel they were not heard and would have liked to give their opinion. But that, well.. so you only get two days, one day to respond and everyone responds.."* (psychologist B; June 2020,well-being panel)

Quote 7: *"First it was all very top-down, now this has changed. We are doing it together and we jointly determine our relationships. The scenarios provide a clear framework, and are known to everyone, client council and works council. Our organization very much wants to develop policy from the work floor."* (policy advisor; November 2020, infection prevention panel)