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Experiences of Social Isolation in Older Hospitalized Patients with COVID-19 and Their Close Relatives: A Qualitative Study

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Abstract

Background: Proximity between older patients and their close relatives is essential during hospitalisation. During the first wave of the pandemic, the Danish Patient Safety Authority restricted no hospital visitors. **Aim:** To explore how older patients with COVID-19 and their close relatives experienced physical separation during hospitalization. **Method:** A qualitative study using semi-structured interviews and thematic analysis was employed. **Findings:** Six interviews were conducted: three patients with a mean age of 81 years and three close relatives—two daughters and one spouse. The patients felt boredom, loneliness, and a sense of imprisonment, yet they felt safe and satisfied. Isolation was known beforehand from the media. Close relatives emphasised that information, involvement, and collaboration with hospital staff were crucial. **Conclusion:** Although older patients with COVID-19 and their close relatives widely accept their situation during hospitalization, they experience negative consequences from social isolation.

Keywords

Aged, COVID-19, Nursing Staff, Hospital, Personal Protective Equipment, Social Isolation, Visitors to Patients

1. Background

The COVID-19 pandemic caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) led to a large number of hospital admissions worldwide [1]. In Denmark, 15,632 patients were hospitalized from March 1, 2020, to

June 25, 2021; of those, 42% were aged 70 years or more [2]. COVID-19 affected everyone regardless of age, however particularly in older patients living with frailty and multi-morbidity and an age-related weakened immune system, the disease was seen to develop into a life-threatening condition. Mortality has been found to be associated with frailty [3], and among Danish hospitalized patients 80+ years old with COVID-19, the in-hospital mortality rate was 31% during the first wave in 2020 [4].

COVID-19 was categorized as a "critical threat to society", which made it possible for the Government to implement restrictions such as the ban on gatherings [5]. The influence on the social life of Danes was invasive, especially in the first year of the pandemic. Only people from the same household were allowed to gather at the pandemic's beginning. Later, the ban was slowly scaled down and in September 2021, the remaining restrictions were removed as COVID-19 was no longer categorized as a disease presenting a "critical threat to society" [5].

In hospitals, significant and necessary initiatives were taken in the fight against the virus, e.g., visitor restrictions and personal protective equipment (PPE). Unfortunately, these initiatives may have had undesirable side effects. Patients infected with COVID-19 were isolated in specialised COVID-19 units with adequate technical facilities for treatment to reduce the spread of the disease to other patients and staff. During specific periods, hospitals were closed to visitors, meaning that visits from family and relatives were restricted [6]. These visitor restrictions severely affected the possibility of involving relatives in the patients' pathway for patients and healthcare professionals (HCP) [7] [8] [9]. In addition, HCPs were acquired to wear PPE, including gloves, aprons, face masks, and shields, when caring for the COVID-19-infected patients to protect themselves and the patients [10]. PPE may have created a physical barrier between patients and HCPs and affected the quality of care provided. During this period and unless the patients were critically ill, the HCPs were the only physical human contact as face-to-face behind a mask the COVID-19-infected patients had during their hospitalization. Literature produced before and during the pandemic states that loneliness and depression are central features of patients in isolation [11] [12] [13] [14]. Systematic reviews of patients' experiences during isolation indicate higher anxiety, stress, and lack of control [15] [16] [17]. In an extensive survey comparing the experience of isolated patients with not isolated patients, isolated patients reported longer timely staff responsiveness to toileting needs, call buttons, and help with pain [18]. In addition, isolated patients experienced not receiving any spontaneous visits from the staff except when a task had to be performed and information about their situation was warranted [7] [19].

In the past two decades, much knowledge has been gained about the importance of proximity between patients and their relatives during hospitalization. The presence of loved ones is significant to hospitalized patients during severe illness [20] [21]. Relatives are no longer viewed as visitors but as active participants and an integrated part of patient-centred care. Especially in older patients with frailty, relatives are a significant information resource for understanding

the patient's situation, primarily when patients cannot provide this knowledge themselves [22] [23]. Relatives state that their emotional support is a vital care activity for older patients [24]. The more relatives collaborate with the nurses, the better their satisfaction with the patient's treatment, and they also experience a reduction in their sense of powerlessness and guilt [25].

Even though research demonstrates how isolation severely affects patients with the feeling of loneliness, induces longer timely staff responsiveness, and impairs the possibility of involving relatives, there is a lack of knowledge of how older hospitalized, isolated patients with COVID-19 and their close relatives experienced this separation during the acute illness. We, therefore, aimed to explore how 75+-year-old patients with COVID-19 in a department of infectious diseases in a Danish hospital experienced isolation and staff usage of PPE. Furthermore, we explored how close relatives experienced prohibited access to the patients. This knowledge should expand research on social isolation in geriatric medicine.

2. Method

2.1. Design and Scientific Framework

With the aim of exploring patients' and near relatives' perspectives, a qualitative explorative study was designed, guided by a phenomenological hermeneutic frame of reference [26]. Data were generated through semi-structured interviews and analysed using a thematic approach [27] [28]. We followed the Equator Network COREQ guideline for qualitative research [29].

2.2. Setting and Participants

During the first pandemic wave from May 1 to June 30, 2020, we collected data in a 22-bed unit in the Department of Infectious Diseases at a university hospital. Family visits were prohibited during the study period. The HCPs enforced the visitor restrictions guided by the Danish Patient Safety Authority [6] in their clinical practice. The hospital unit was located on the ground floor. Every single bedroom had a door with direct access to the grounds. Despite prohibited visits of relatives in the unit, the bedrooms on the ground floor made it possible to facilitate visits of relatives at a distance, allowing the relatives to stand outside by the open door. In some cases, it gave patients and relatives access to see and communicate without having physical contact.

In the two-month period, all non-intensive care patients aged 75+ admitted to the unit with laboratory-confirmed COVID-19 were asked for participation or oral consent to contact their relatives for interviews. Inclusion criteria for both patients and relatives were cognitively well-functioning, informed consent, no hearing and speaking problems, and Danish speaking. The patients and relatives were not paired for the interviews.

2.3. Data Collection

Data was collected using a thematic, pilot-tested interview-guide focused on

three themes concerning the patient and the relative's experience: 1) the patient being in isolation, 2) the HCPs' use of PPE, and 3) communication between the patient and HCP, and relative and HCP. Questions in the interview-guide addressed the patients' and relatives' experiences of the pathway before admission, during hospitalization, and at discharge. Moreover, the participants were asked how frequently they usually met with their closest relatives and their communication habits in daily living and during earlier admissions, thus establishing insight into behavioural patterns before the infection. The interviews were conducted by three researchers (KY, NRDK, and PE) one week after discharge over the phone due to the Danish Health Authority's recommendations to prevent the virus from spreading. The three interviewers were gathered in the same room during the interviews to check fidelity. The interviews were digitally recorded and transcribed verbatim, and quotes were translated into English. The participants were not compensated for their time and efforts.

2.4. Data Analyses

The first and the last author performed a structured thematic analysis in five phases to identify patterns of meaning across data [27] [28]. After becoming familiar with data, the authors read each interview separately, and passages linked by common themes were highlighted, grouped, and integrated. Interim themes were searched for patterns emerging across the interviews, leading to final themes and subthemes. Each theme was reviewed and validated by tracing chosen patient quotes supporting the theme in their respective interviews, thus ensuring that the meaning was intact. All authors qualified for the final analysis.

2.5. Ethical Considerations

The Hospital Committee approved the study for COVID-19 projects at our hospital. According to Danish law regarding qualitative research, the study did not require formal approval from the Ethics Committee of the Central Denmark Region [30]. On the day of discharge, the patients were asked for oral consent to be contacted by phone one week later or for oral consent to contact their relatives. During the phone call, the patients or their relatives were verbally informed that participation was voluntary. If oral consent for recorded interviews was confirmed during the phone call, the patients received an informed consent form to sign and return in a stamped envelope, which was provided. They were informed that their identities would not be disclosed. The research was conducted according to the Declaration of Helsinki [31].

3. Findings

In the period for data collection, eight 75+ years old patients were eligible for inclusion. However, one patient died, one suffered from severe dementia, one did not understand Danish, one was transferred to the intensive care unit, and one declined participation in the patient interview. In total, three patient interviews

were conducted. In three of the five non-interviewed patients, informed consent was obtained to interview close relatives (two daughters and one spouse). Each interview took an average of 30 minutes. Table 1 shows the characteristics of the participants.

The structured thematic analysis was performed across the six interviews and resulted in the following three themes "Isolation", "Personal Protective Equipment, PPE", and "Contact with close relatives".

3.1. Isolation

Patients and relatives commonly acknowledged and accepted the situation with isolation. They seemed to understand the reasons for isolation were to control the spread of the virus and to protect their family and the HCPs, as illustrated in the following quotes,

> "I was very ill, and I needed to go into isolation to decrease the spread of the virus." (ID1)
> "With a disease like that [COVID-19], you need to be confined; we were just happy that she could be treated." (ID6)

However, at the same time, the isolation was described as depriving the patients of their regular social contact and was related to feelings of boredom, loneliness, and imprisonment:

> "It is a long time to be imprisoned for 14 days. You're normally not confined to bed but can go into the dining room." (ID2)
> "We're normally used to being free, and suddenly, because of this disease, she had to be caged in. I think that was rather intense." (ID5)

Both the older patients and the relatives described how the required isolation during hospitalization was an extension of the patients' habits in their own homes during the pandemic, where physical contact with family and friends was close to non-existing.

> "We have been so cautious. Nobody has been in our house for more than two months except for those helping me shower." (ID2)
> "It was the same at the nursing home where my mother also was confined to her room where no visits were allowed." (ID4)

Table 1. Characteristics of participating patients and close relatives.

ID number	Patients	Relatives	Length of patients' hospital stay
1	Female, 86 years		19 days
2	Female, 82 years		12 days
3	Male, 75 years		10 days
4		Daughter	14 days
5		Daughter	6 days
6		Husband	14 days

The fact that they were used to isolation at home may have added to the patients and their relatives' acceptance of the isolation demands at the hospital. Furthermore, especially in these first months of the pandemic, the media news flow portrayed the horrific consequences of the COVID-19 virus, for example, daily updates of the number of deaths in Italy.

"We saw so much about it on the television. It was only logical [to be isolated]." (ID2)
"It was scary that she extracted the virus, but I was aware of the situation in our community through the media coverage." (ID5)

3.2. Personal Protective Equipment, PPE

As well as being prepared that infection with COVID-19 would require patients to be isolated during hospitalization, patients and relatives seemed to be prepared for the HCPs' use of PPEs. The usage of PPE was seen as necessary to protect others. Up front, the patients expressed that PPEs did not negatively affect their experience of being hospitalized:

"I felt safe knowing that it [the PPE] was used to protect them. I knew that it was the reason they had it on." (ID1)

However, at the same time, the patients and relatives found the use of PPEs made the HCPs resemble robots and appear inhuman and impersonal:

"My mom told me that they looked like astronauts dressed in spacious suites." (ID6)
"They looked like robots, but they treated me well. It seemed a bit artificial." (ID1)

The patients displayed to understand the inconvenience PPE represented for the nurses when they had to get in and out of the PPE several times daily:

"…they had to change clothes many times a day, which took a lot of time—so I told them not to enter my room but to leave the things they forgot by the door, where I could pick them up myself." (ID2)

As demonstrated in this quote, the patient's concern for the nurses' well-being and time-consuming activity dressing in PPEs minimised HCPs presence and contact, as HCPs only entered the isolation zone when necessary.

"There wasn't much traffic in and out of the room. I felt isolated, but that's how it's supposed to be [because of COVID-19]. I was very lonely with no one to talk to. But they [the HCPs] were extremely kind and friendly." (ID3)
"They [the HCPs] came in and left again quickly. There wasn't much contact." (ID2)

As illustrated by these quotes it was the patient's choice to help HCPs minimise their use of PPEs. However, this action seemed to affect the patients' opportunity to interact with the HCPs and induced feelings of loneliness and being

left alone.

3.3. Contact with Close Relatives

Being hospitalized and in isolation during the COVID-19 pandemic resulted in alternative contact and communication between patients and their relatives. This contact was either initiated by the patients, their relatives and/or the HCPs. The patients expressed having had daily telephone contact with their relatives. They seemed satisfied and even surprised by this, as the frequency of communication was sometimes greater than they had experienced under previous admissions.

> "We had contact through the phone. I think they contacted me many times during the day." (ID3)
> "I talked with her on the same day she was hospitalized. I called the hospital and asked the nurses if I could talk to my mother, and I believe I was told she had her mobile phone with her so that I could call her directly." (ID4)

Being able to maintain contact through a mobile phone was found to be valuable for older patients and their relatives. However, due to the patient's severe illness and/or dementia, this online contact with the family was not always possible.

> "It was tough. We couldn't communicate with her as she could not talk on the phone because of her Alzheimer's and was so sick with Corona." (ID4)

The department for COVID-19-isolated patients was placed on ground level. It opened alternative ways for the HCPs to initiate, support, and maintain contact between patients and their relatives.

> "My family came to visit me. They were not allowed to enter the room, so they stood outside the door, and we talked. It was lovely to be able to see them. It was not the same to talk on the phone as seeing them in person." (ID1)
> "Yes, I was happy that it was possible to see her this way." (ID6)
> "I did not visit her—just through the door." (ID5)

On one side, the patients and relatives expressed being pleased with the opportunity to maintain contact despite the contact being at a distance. On the other side, when comparing admission experiences during the COVID-19 pandemic to previous admissions, where one or two daily visits were standard, patients and relatives expressed both lesser frequency and quality of these alternative visits through the terrace door. However, considering the requirement for a no-visitation policy during the first months of the pandemic, patients and relatives seemed to accept these conditions for a physical visit. They indicated that the physical visit brought greater joy than a phone contact.

4. Discussion

In this study, we identified that older patients hospitalized with COVID-19 ex-

perienced feelings of isolation, loneliness, and boredom. This effect of isolation is not new as it has been described in studies made both before and during the COVID-19 pandemic focusing on younger patient groups. Furthermore, knowing that isolation may increase the risk of stress, and lack of control for older patients, underlines the vulnerability of these patients. Therefore, it is imperative that HCPs understand the importance of alleviating the older patients' loneliness and not diminish it as minor because it could potentially negatively affect their mental health and, ultimately, their recovery.

Our study demonstrated how the COVID-19 restrictions diminished the contact between patients and the nurses, as patients had less physical contact with staff during isolation compared to previous hospitalizations. However, patients and relatives understood and accepted the necessity for isolation and seemed content with the quality of care. Contentment was communicated in wage terms and constantly in and combined with something that could be understood as a critique, for example, "I was very lonely…but the HCPs were kind and friendly", "They looked like robots. However, they treated me well" and "…we were just happy that she could be treated." On the surface, the patients and the relatives seem content with the provided care; however, these expressions could also be interpreted as efforts to adapt to an uncontrollable situation. Lou *et al.* [32] describe COVID-19 as life-threatening and disruptive to lives of individuals and how patients' adaptive responses with good behavior during healthcare contacts. They also suggest a need for HCPs to focus on patients' ontological security. The patients and the relatives in our study struggle with the same ontological insecurity. Perhaps their cautious statements are rooted in their need for support from the HCPs to feel safe and secure. In a way, they accept the help they are offered with gratitude, even though it may not be all they need. A recent Danish study explored how older patients without a COVID-19 diagnosis and admitted to a geriatric unit with visitor restrictions experienced hospitalization during the pandemic [33]. The study shows that patients needed compassionate care from the HCPs and that patients found that proximity of the HCPs enabled them to identify and understand their patients' needs. However, the ability of HCPs to be close to the older and vulnerable patients in our study was challenged due to isolation and the use of PPEs, which ultimately can impact the HCP's ability to exercise compassionate care. Compassionate care is pivotal as it can increase patients' emotional well-being and benefit their recovery and survival rates [34].

Our study demonstrated how isolation and the usage of PPEs clearly reduced the HCPs' physical presence and contact with the patient. These findings are comparable to studies conducted before the pandemic [16] [17]. The significance of our results is that they describe how the patients contributed to their own confinement and loneliness by asking the nurses to leave food and beverages outside. Even though research has shown that older patients express more satisfaction with the care provided than younger patients [35], this could again express their effort to adapt to the situation by displaying what they perceive as good behavior.

The media coverage of COVID-19 in newspapers, radio and television during the first wave of the pandemic prepared patients and relatives of potential consequences of becoming infected regarding hospitalization, isolation, usage of PPEs, and possible death. Being well-informed may have eased patients' and relatives' acceptance of the need for isolation and PPE usage. However, our study points out implications for older patients' care quality; for example, nurses limited the number of visits and decreased their time in the patient room. It may inevitably have decreased the HCPs' ability to get to know the patient and to identify and meet the patient's most urgent needs, as building rapport and relationships relies on presence and communication [36]. Thus, it may have compromised the quality of care.

The older patients and relatives in our study describe how HCPs, in some situations, worked around the isolation and visitor restrictions, and arranged visits at a distance through an open door. Other contact forms were exercised through a phone call between the patient and relatives. The physical visit was preferred over contact by phone as it made it possible for the relatives to see the patient with their own eyes. The challenge identified in the setting of older isolated COVID-19 infected patients is that using a phone may be impossible due to e.g. dementia and speech or motor impairments. In these situations, the relatives' only point of contact with the patient is through the HCPs. A recent study found that only 33% of geriatric patients aged 65+ years are smartphone users [37], and that older smartphone users often need assistance from their relatives. Even though smartphone-based videoconferencing has been shown to effectively reduce feelings of loneliness and improve physiological health and vitality [38] and videoconferencing improves emotional connections through facial expressions and nonverbal communication [39], this communication tool may only apply to some patients in our specific setting with older patients. It displays the importance of the alternative ways of creating contact between patient and relatives exercised by HCPs in our study.

5. Methodological Considerations

Our study has some significant limitations to be considered when interpreting the results. The interviews were conducted in Danish, facilitating good communication, verbatim transcription, and a refined understanding of narratives. When translated into English, there was a risk that some of the meanings of the respondents' statements would disappear. In addition, only three interviews were conducted with patients and three with relatives. Due to the few interviews with close relatives, we cannot conclude whether there is a difference in how the relatives experience their role as relatives, depending on whether they are daughters or spouses of the patient. More patient interviews may have brought new themes into the study.

Clinical implications

Our findings show that refinements of existing hospital guidelines for fami-

ly-centred care in older isolated patients are needed as close relatives are significant resources during hospitalization. The question is what healthcare professionals could do to mitigate the discomfort, loneliness, and boredom that older patients with COVID-19 experience during social isolation. During a pandemic, physical distancing requires the adaption of standard practices. Innovative approaches that involve close relatives in patient care during hospitalization are essential since they can lead to better patient satisfaction and progress in care [39]. Older patients in isolation should have digital solutions by the bed for having contact with more than one close relative several times daily. The hospital staff must assist in applying these solutions. In older patients with cognitive impairment such as dementia, close relatives need physical contact; therefore, the relatives' use of PPE in the isolation unit next to the patient is necessary. Staff should establish a structured and informative communication plan with the older patient and close relatives shortly after admission. Any barriers to daily communication and engagement should be identified, and alternative ways of communing and engaging must be adapted.

6. Conclusion

Older patients with COVID-19 experience discomfort, loneliness and boredom during social isolation. The isolation and staffs' use of PPE negatively affects communication with the nurses and other HCPs. Despite negative experiences of isolation, the patients accept the situation and have no specific suggestions for changes. Close relatives need to be involved and daily informed about their loved one's condition, and physical and visual contact with their loved ones is highly requested. Prior knowledge about COVID-19 restrictions from the media makes isolation in the hospital more acceptable when it is expected to occur.

Author Contributions

All the authors have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data.

All authors have been involved in drafting the manuscript or revising it critically for important intellectual content.

All authors have given final approval of the version to be published, and have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

All authors have agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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Conflicts of Interest

The authors declare that there are no conflicts of interest.

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