Deutscher Ethikrat

A Modicum of Social Contact in Long-term Care during the Covid-19 Pandemic

AD HOC RECOMMENDATION

Berlin, 18 December 2020

I.

Physical distancing is one of the central protective measures in the context of the Covid-19 pandemic. In long-term inpatient care (care for the elderly and disabled), this has led to far-reaching restrictions and bans on visits and contacts. In addition to relatives and other close persons, these measures also include(d) external medical, therapeutic and pastoral care and support and occasionally even le(a)d to the isolation of a patient in his or her own room. The requirement of physical distancing is certainly an important part of improving everyday hygiene in an effort to prevent infection with Sars-CoV-2 and severe or even fatal illness. However, this requirement increases the risk of isolation, significantly reduced social participation and considerable decline of health, especially in long-term care facilities. This conflicts with central demands for example of the UN Convention on the Rights of Persons with Disabilities, the *Pflege-Charta* (Charter of Rights for People in Need of Long-Term Care and Assistance) and the *Sozialgesetzbuch – Elftes Buch* (German Social Code – Book XI) calling for a life that is as independent and self-determined as possible, with social participation and in accordance with human dignity. For people with a long-term need for care, the experience of belonging to the community is often inextricably linked to physical presence and especially to closeness through touch.

The danger of social isolation for residents of long-term care facilities has been recognised by German legislation in that the recent amendment to the *Infektionsschutzgesetz* (Protection against Infection Act) prohibits complete isolation for such facilities and stipulates a *minimum level of social contact* (Section 28a (2) sentence 2 Protection against Infection Act). However, the provision does not cover all relevant contexts, in particular neither the many additional visiting restrictions imposed or recommended by the facilities nor contact restrictions within a facility. Most notably, it remains open what the required minimum level of social contact consists of and by what means this minimum level can be ensured in the daily routine of the care homes, even under the conditions of an extreme pandemic emergency.

In this Ad hoc Recommendation, the German Ethics Council therefore sets out to define a minimum level of social contact from the perspective of those living in long-term care facilities and recommends measures to ensure this minimum level. The Council explicitly recognises the high pressure that employees in the long-term care sector are confronted with today. The following recommendations are not intended to add to these burdens. Rather, the institutions should be given comprehensive support in implementing the measures.

II.

Not only the quantitative component (number of contact persons, frequency and duration of individual contacts) is decisive for the minimum level of social contacts, but also and above all their *quality*. Quality refers to those contents and features of contacts which, *viewed from the perspective of the individual long-term care resident*, are of particular importance for well-being. Therefore, efforts should be made to enable residents to have contacts with those people with whom they have an emotional and trusting relationship. The selection of these people is up to the person concerned and must not be made without his or her due participation. It should be taken into account that especially in old age, there is an increased interest in contacts with intensive emotional exchange. This emotional exchange, which often includes physical closeness, in a peculiar way creates a sense of acceptance and belonging.

By establishing biographical continuity, visits from relatives and other close persons are usually experienced as particularly significant by care home residents and are therefore essential for them. However, contacts within the facility also fulfil an important function: they strengthen the sense of being part of a community. This is especially true for relationships of mutual support between those living in a facility. Furthermore, the potential of respectful and genuine contacts with both salaried and voluntary workers should be emphasised. This potential also lies in the cognitive, emotional and social-communicative stimulation that positively influence the residents' attachment to and quality of life and the way they shape their everyday life.

When defining a minimum level of contact, reference has to be made to *interpersonal contacts* characterised by physical presence. They are at the core of experiencing relatedness and participation. Without any doubt, digital communication technologies such as video calls and conferences in particular can also provide this experience, and must therefore be promoted. Nevertheless, they cannot completely replace necessary physical closeness.

In practice, the contact management should pay attention to the residents' highly individual needs. It must be taken into account that in situations of severe disease and extensive need for care, a caring attitude characterised by emotional and physical closeness is even more important for the individual's quality of life. To be taken care of in this way helps people to cope with borderline situations of mental health. In addition, it can even strengthen residents' emotional and mental resources to such an extent that they not only find (back) to a stable outlook on life, but are also encouraged to embrace already existing opportunities of improving health and everyday competence.

In the case of *mental disorders* (e.g. depressive disorders and anxiety disorders as well as delusions) and neurocognitive diseases (such as mild cognitive impairment and the various forms of dementia), contacts in which the residents of long-term care facilities receive emotional, mental and social-communicative stimulation become even more important. Thanks to these contacts, those affected not only experience urgently needed stimulation, but also the biographical continuity that is important for maintaining identity. The ability of contact persons to correctly interpret the facial expressions and gestures of residents is particularly important when they are less and less able to express themselves verbally.

The dying are dependent on emotional, spiritual and, where desired, pastoral support because it can help them to look back on their lives and to verbalise spiritual or religious concerns. In addition, accompaniment in the last phase of life fulfils an important function with regard to the gradual detachment from life and from the areas of life to which the person concerned feels particularly attached. Through the accompaniment, which can also be experienced physically, the dying are helped to adjust to dying and accepting the approach of death. Without such contact, the approaching death is experienced even more as a threat (if not outright destruction). Emotionally sustainable support is not only important for the dying. It is also a wish of relatives and other close persons to accompany people living in long-term care facilities during the last phase of their lives and bid them farewell. Not having been able to accompany a dying person may give rise to feelings of guilt. When it comes to accompanying the dying, the important contribution of volunteers with sufficient experience in accompanying seriously ill and dying people has to be acknowledged once again.

In view of the special pressure caused by the pandemic, particularly for long-term inpatient care facilities, there is an urgent need for effective support measures in the short term to relieve the burden on staff and thus ensure compliance with the minimum standards described here. The support provided by volunteers – many of whom are already active in the facilities – should be expanded. In addition, the commitment of additional qualified staff (e.g. students) should be promoted, if necessary also through remuneration. It is a political task at federal and state level to create a reliable framework for this as soon as possible. This also includes provisions to ensure that safety standards (e.g. for rapid tests and protective equipment) can also be met by volunteers.

III. Recommendations

- The basic idea of Section 28a (2) sentence 2 Protection against Infection Act, that a minimum level of social contact must be maintained, has to be consistently observed and implemented in all forms of visiting and contact restrictions in long-term care facilities. This should also be controlled – for example, during the official verification of the facilities' pandemic plans.
- The minimum level of social contact should not be determined in an abstract and general way, but from the perspective of each individual resident and his or her living situation. In doing so, not only purely quantitative, but also qualitative aspects should be taken into account.
- Especially if relatives are missing, civically engaged persons should be involved at the request of those living in long-term care facilities.
- Forms of virtual contact should be offered and actively supported. However, the possibility of physical contact must always be given if it is desired.
- The dying must be given the possibility of continuous accompaniment by relatives and other close persons and – if desired – by chaplains and/or volunteers in hospice services.
- Services that improve the integration, participation and quality of life of those living in long-term care facilities by means of social contacts and that foster or maintain their physical and mental resources should be realised (everyday structuring, stimulating, rehabilitative activities). The involvement of qualified volunteers should be promoted considerably.

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