LETTERS TO THE EDITOR

RESEARCH STUDIES

Outbreaks of COVID-19 infection in aged care facilities in Japan

Dear Editor,

COVID-19 is a worldwide pandemic that is infecting all parts of society, but presents a disproportionally high risk of death to older persons. Aged care facilities are one of the most vulnerable locations for COVID-19 infection, and we believe that it is important to report the outbreaks of COVID-19 in aged care facilities in Japan, which significantly differs from the situation in Europe and the USA.

Regarding the situation in Europe, a survey carried out by London School of Economics on five European countries (Belgium, France, Spain, Ireland, Italy) reported that 42–57% of all deaths as a result of COVID-19 occurred in aged care facilities (Table 1).1, 2 For example, in Belgium, 90% of the residents in aged care facilities were infected, and in Italy >100 older persons from a single care facility died of COVID-19 infection.3

Japan has one of the largest populations of older adults in the world. In 2017, 28.7% of the population was aged >65 years, and, currently, 1 million older persons live in care facilities and 4 million older persons utilize day care facilities. The spread of COVID-19 infection has occurred in some of these facilities in Japan; however, in contrast to Europe, to date, the number of people infected has remained relatively low, and there have been few deaths due to infection. On 23 April 2020, an outbreak of infection was confirmed at an aged care facility in Chuo-Ku, Tokyo, where eight people were infected, and from late April to 6 May, 14 people including residents and staff were infected with COVID-19 at a facility in Meguro-Ku, Tokyo.4

The incidence of COVID-19 infection and deaths at aged care facilities has been reported by a number of outlets. According to the Ministry of Health, Labor and Welfare, 40 out of 250 outbreaks nationwide have occurred in facilities for older persons.5 At the end of April 2020, the national broadcaster, NHK, reported that 550 people in aged care facilities (380 users, 170 employees) had been infected; however, just 60 people, (10%) died.6 In another report from the national newspaper, Mainichi Shimbun, on 13 May, 20% of the total COVID-19 fatalities were related to facilities for older persons.7 Most of the older residents living in aged care facilities in Japan have cognitive decline, which might impair their ability to keep their masks on and wash their hands, as well as maintain social distancing.

There were 26 deaths related to day services for older persons.7 In day care facilities, an additional effect of COVID-19 is that many facilities have had to suspend their services due to the spread of infection in the local region, and the number of facilities that have stopped provision of day care services has been increasing. Under this situation, without additional support for aged care facilities, there is growing concern about the possible collapse of aged care in Japan.

Aged care facilities are not subject to the lockdown requests due to the emergency declaration, and prefectural governors have been requested to keep providing day services and short stay respite care. However, according to interviews carried out by NHK with the local governments of seven prefectures, as of 15 April, 249 aged care service facilities had closed of their own volition. The main reasons for closing were concerns about prevention of infection due lack of hygiene products, such as masks and disinfectants, and lack of staffing.

Closure of day care facilities has a considerably detrimental effect on the life of their clients, because most will remain inside their home, often spending most of the day watching television, which when prolonged will result in the decline of physical and mental functions, as well as progression of dementia. Day service facilities play a vital role to prevent outbreaks of infection, as well as to maintain essential services to older persons living in the community. Of these services, the bathing service is the most urgent, because often older people take a bath at their own home and might not be able to take a bath for over a week if day care facilities are closed.8

In aged care facilities, the level of medical care, such as medical staff and medical equipment, is not high, compared with medical institutions. Additionally, there are much greater shortages of medical-grade protective equipment, such as gowns and masks, compared with medical institutions.9 There are no infection control personnel at aged care facilities, and knowledge and skills of infection control among staff are usually insufficient. There is an urgent need to take measures to address the management of COVID-19 infection in older people living in aged care facilities. When infections do occur in aged care facilities, it is critical that medical experts and medical equipment is provided by the state and local governments.10 It is a welcome statistic today that a relatively small number of deaths have occurred in Japan, but without medical personnel and equipment, as well as financial support, there is a high likelihood that the large numbers of infections and deaths of older people that have been seen in Europe will also occur in Japan.

Table 1 Percentages of confirmed COVID-19 deaths related to care homes

| Country | % |
|---------|---|
| Norway  | 64 |
| Canada  | 57 |
| Ireland | 55 |
| Spain   | 52 |
| Belgium | 46 |
| France  | 49 |
| Singapore | 20 |
| Australia | 14 |

Mortality associated with COVID-19 outbreaks in care homes as a percentage of total deaths in a country (TRTWorld).

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Disclosure statement

The author declares no conflict of interest.

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Exploration of etiological perspectives for ageism in geriatric care: A qualitative analysis of the most popular ageism scales

Dear Editor,

Ageism is the stereotyping, prejudice and discrimination against people based on their age.1 For older people, ageism is a widespread everyday challenge with harmful effects on their health due to their marginalization and exclusion in healthcare settings. Physicians and nurses should be particularly knowledgeable about the aging process and empathetic toward older people.2

However, physicians and nurses do not receive sufficient training in geriatrics.3 There is ample evidence of ageism among physicians in diagnostic procedures, treatment of older patients and interactions with older patients.4 Previous studies also suggested that nurses lack accurate knowledge about the aging process, express higher levels of anxiety about aging and show a tendency to assign a lower status to geriatric nursing.5,6 Physicians and nurses in the field of geriatrics should recognize their ageist attitudes and better understand the rationale for examining the etiology of ageism in medical care settings.

Although a number of previous studies conducted among samples of medical professionals have given concrete common examples of ageist speech and behavior,7–9 overall, few models clarifying the origins of ageism at the individual level among medical professionals have been derived from findings to date. Our study aimed to describe the perspectives that influence medical professionals’ attitude towards ageism. Therefore, the authors extracted qualitative data from a relevant study that aimed to validate a revised and extended version of Palmore’s Facts on Aging Quiz, which is one of the most commonly used ageism scales among health professionals.2 The quiz was designed to measure basic knowledge of physical, mental and social facts about old age and aging as well as common misconceptions. The extended revised version of the quiz is a combination of Palmore’s Facts on Aging Quiz and Facts on Aging Mental Health Quiz. A validity psychometric testing was conducted among 1141 nursing students from 13 nursing institutions in Flanders, Belgium. Most of the participants were first-year students (70.2%), female (77.5%) and somehow experienced (75.5%) in elderly care.2 Items incorporated in the revised and extended version of the quiz have been shown in Appendix S1 (see Supporting Information). All 36 items of the revised version of the quiz was considered as individual meaning units. The qualitative data were analyzed using a qualitative content analysis approach.6 After thorough reading, individual units were grouped to compare them and match the similar thematic units. Then similar meaning units were grouped into categories and themes were formulated. The process was repeated several times until the major themes and sub-themes were evolved.

As shown in Table 1, three major themes anchoring eight sub-themes explaining the etiology of ageism in geriatric care were identified. The major themes are characteristics of elderly people, disparity and health status. Although they are generally thought to be frail or in need of care, most older people are healthy enough...