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Lessons in Ethics from Nursing Home Stakeholders: Residents, Close Relatives, and Volunteers on COVID-19 Restrictions

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Abstract

In 2020, amid the COVID-19 outbreak, national governments introduced strict measures—including visitor bans, prohibitions on group activities, and quarantine protocols—to shield nursing home residents from infection. With safety as the overriding priority, residents and their close relatives were compelled to accept these limitations. Their viewpoints matter greatly because the policies profoundly affected their lives, yet they were left out of the decision-making process. This study explores the moral perspectives of residents, close relatives, and volunteers on the restrictions in hindsight, along with the key moral lessons they believed should be drawn from the experience. We conducted 30 semi-structured interviews with residents and close relatives, as well as one focus group discussion with volunteers in nursing homes. All data were transcribed verbatim and analyzed inductively. Following this, three Socratic dialogue sessions were held with residents, close relatives, and volunteers. In these meetings, initial findings were presented, and conversations were guided toward identifying moral lessons for future pandemics. The results were then integrated with moral theory using an empirical bioethics approach.

Over time, participants developed increasingly critical views of the COVID-19 restrictions. Multiple moral values were undermined, thereby shaping important moral lessons for the future. The participants highlighted three moral lessons as particularly significant. First, it is essential to develop tailored and well-balanced solutions in real-world settings. Second, greater recognition must be given to the practical caring role performed by close relatives. Third, decision-making power should be distributed more responsively, ensuring that the perspectives of all affected stakeholders are taken into account. Placing these findings alongside moral theory reinforces the argument for actively including all stakeholder groups in future decision-making processes. To make the moral lessons more concrete, tailored solutions can be achieved through moral case deliberations. Proper recognition involves steps toward moral repair and the inclusion of counter-stories in public discussions. A responsive distribution of power begins with delivering clear, trustworthy information and genuinely incorporating all relevant perspectives.

Keywords: COVID-19, Nursing homes, Restrictive measures, Moral lessons, Residents, Close relatives

Introduction

When the COVID-19 pandemic reached the Netherlands and Flanders (Belgium), national governments required nursing homes to ban in-person visits. As a result, close relatives and most volunteers could no longer enter the facilities to see residents. In addition, shared spaces were closed, and all group gatherings and social activities were canceled [1, 2]. Furthermore, in many elderly care organizations, residents were required to remain in quarantine within their own rooms. These measures aimed to stop the virus from spreading among residents

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and staff, thereby preventing severe illness and deaths [3]. However, the restrictions led to residents being physically separated from their close relatives for several months, raising concerns about heightened loneliness and declines in quality of life and wellbeing. Most residents maintained some contact with family through remote means, such as telephone or video calls and waving through windows [4]. Given that close relatives are known to influence residents' wellbeing [5, 6] positively, the restrictions were anticipated to harm residents' lives. Shortly after the measures were introduced, numerous newspaper articles described the negative consequences of the visitor ban, highlighting increased loneliness and diminished quality of life among residents. This prompted questions about whether the restrictions justified their costs [7-9]. At the same time, scientific publications began documenting the potential damage caused by social isolation to residents' mental wellbeing [10-14]. Studies also indicated that the measures failed to completely halt rapid virus transmission within nursing homes [15]. Nevertheless, despite the clear importance of hearing from those most directly impacted, almost no research examined the normative views and lived experiences of residents, close relatives, and volunteers [16].

For this reason, within a broader multicenter qualitative research project [17], we investigated the effects of the restrictive COVID-19 measures on residents, close relatives, and volunteers—focusing on their social needs, experiences of loneliness, and the lessons that could be learned. As one component of this project, we examined how these groups retrospectively evaluated the restrictions. We asked them which values and norms they regarded as (most) important and what normative lessons should guide future responses. We were especially interested in their opinions because they had been largely excluded from decision-making on the restrictive measures. In this article, we present their normative perspectives and lessons, and explore their implications for future policy development.

Materials and Methods

This investigation was part of a wider study exploring the effects of restrictive policies introduced during the COVID-19 outbreak. The broader study focused on loneliness, social needs, and resilience as experienced by nursing home residents, their families, and volunteers. Funding for the project was provided by the Netherlands Organization for Health Research and Development (grant number ZonMw 10430022010010). The overall project examined these four main research questions: 1) What is the impact of restrictive measures on experiences of loneliness and social needs of nursing home residents, close relatives and volunteers?, 2) What is the impact of restrictive measures on social relationships and social contact of nursing home residents, families and volunteers?, 3) What is the impact of restrictive measures on the resilience of nursing home residents, close relatives and volunteers and how they help to diminish consequences of restrictive measures?, and 4) What are the lessons learned for policy and healthcare delivery in case of a second wave outbreak of COVID-19 to diminish consequences for nursing home residents, families, and volunteers?

The project was carried out through three academic networks that partner universities with regional healthcare providers serving older adults (i.e., UNO-UMCG, University of Groningen; Tranzo, Tilburg University; HIVA, KU Leuven). Data collection spanned multiple areas in the Netherlands and the Dutch-speaking region of Belgium, where both the applied restrictions and the severity of COVID-19 infections varied. This allowed us to recruit a varied group of participants and collect insights from distinct settings. We intended to develop a thorough understanding of how the measures influenced residents, family members, and volunteers. Ultimately, we pooled all findings together because no substantial regional differences emerged.

From the project results, three broad themes emerged: (1) fulfillment of social needs and associated negative emotions, including loneliness [17]; (2) resilience and available resources for reducing the harmful effects of the restrictive measures; and (3) moral attitudes together with moral lessons viewed from the standpoint of residents, close relatives, and volunteers.

Study design

The present qualitative inquiry concentrated on the moral viewpoints and moral lessons articulated by residents, relatives, and volunteers. We drew on material from 30 interviews held with nursing home residents and close relatives (conducted either jointly or individually), plus one focus group session involving volunteers. Analysis centered on moral aspects of the data, uncovering the underlying values and ethical concerns reported by nursing home residents, close relatives, and volunteers. Beyond this, we organized three Socratic dialogue

sessions to promote open discussion of moral positions and dilemmas. Socratic dialogue is an approach that encourages deep philosophical exchange within a group. It prompts participants to examine topics thoughtfully through conversation. Although classical Socratic dialogue seeks truth, modern uses emphasize the development of critical reflection and practical wisdom. Key features incorporated here were: (1) a specific focus—in this case, values and norms related to the visitor ban as actually experienced; (2) highlighting pivotal moments or examples where values and norms came under pressure; (3) collaborative examination of the fundamental meaning of those moments; and (4) consideration of potential conclusions, here expressed as moral lessons for the future [18].

These Socratic dialogue meetings brought together participants representing different stakeholder groups: nursing home residents, close relatives, and volunteers. The goal was to stimulate collective reflection that would yield a richer understanding of the normative frameworks that shape how people interpret their experiences [19]. This method fitted the research question well because it required participants to anchor their moral intuitions in real situations they had lived through and to weigh their views against those of others, thereby clarifying their own stance. The main questions guiding the sessions were: 'What should not be forgotten if another pandemic arises?' and 'What are the minimum standards that must be upheld?' The facilitator served purely as a Socratic guide. The first two authors moderated the meetings; both had received training in moral case deliberation and possessed practical experience with Socratic dialogue techniques [20, 21].

Recruitment and data collection

Participants came from psychogeriatric and somatic units located in Flanders (Belgium) and in the northern and southern parts of the Netherlands. We recruited through nursing homes and via social media. The research team contacted facilities in the summer of 2020. By then, the formal visitor ban had ended, yet certain restrictions, such as mask mandates and physical distancing in communal spaces, remained in place. Staff members helped identify potential participants and gave them an information sheet describing the study's aims. When a resident's cognitive capacity was limited because of dementia, the legal representative received the same information. A public notice on the research group's website and LinkedIn account produced one additional volunteer response.

Inclusion criteria required that 1) residents had been living in a nursing home in the northern, eastern, or southern regions of the Netherlands or in Flanders, Belgium, when the visitor ban began in March 2020. Close relatives were individuals with a family member or partner residing in a nursing home during that time. Volunteers were unpaid workers at a nursing home during the visitor ban. Everyone needed to be fluent in Dutch. We recorded various background details, including sex, gender, level of physical and cognitive impairment, type of family relationship (i.e., child, sibling, partner), and volunteer characteristics (i.e., age, length of service in the nursing home, kind of voluntary tasks performed, and local severity of the COVID-19 outbreak).

All individuals received full information about the study and gave written consent to audio recording and to the use of their anonymized data in publications. For residents with impaired cognitive abilities due to dementia, consent was obtained from a proxy. People with advanced dementia were not invited to take part.

Interviews were conducted in person at the nursing homes and were scheduled to last no more than 60 minutes. Researchers followed the prevailing rules by wearing face masks and observing social distancing during data collection. The volunteer focus group and all three Socratic dialogue meetings were held online, and each lasted about 90 minutes. The topic guides used for the interviews, focus group, and Socratic sessions are included in the Appendix.

People who joined the interviews ranged in age from 57 to 101 years and represented both residents and close relatives across the different regions (Northern Netherlands, Southern Netherlands, and Flanders). The ten volunteers in the focus group had all been active in nursing homes in these regions before the pandemic began (N = 10). Only two continued their involvement throughout the restrictions; the rest were either obliged to pause or chose to end their voluntary service. Each of the three Socratic dialogue meetings included a mixed group. Altogether, two residents, five close relatives, and six volunteers attended these sessions.

Data analysis

All interviews and focus group sessions were audio-recorded and transcribed in full. The research team then conducted a thematic analysis of each transcript and

coded it using ATLAS.ti version 8 software, adopting a fully open and inductive strategy. To begin, researchers (EL, NH, FV, JW, AS, and SN) thoroughly read and collectively discussed the first interview transcript. After that, EL, FV, JW, and SN independently coded this transcript and later compared their codes. These discussions produced an initial code set. The same procedure was applied to the second interview, yielding a code tree. The other interviews were distributed among the researchers based on geographic region. To boost reliability, a researcher from another region independently reviewed the coding. Any differences were resolved in group meetings until everyone approved the final version of the codes (for instance, through negative case analysis and peer debriefing). Participants were given a member check to verify the material and provide any additional input on what they had shared. This step resulted in only a few minor additions.

Following the coding phase, the team specifically identified passages that expressed moral emotions and normative positions. This work was informed by the approach of empirical bioethics [22, 23] and drew on interpretive ideas from Gadamer's hermeneutic philosophy [24, 25] to achieve a thorough understanding of the moral attitudes, values, and norms involved.

Additionally, the Socratic dialogue meetings were examined through a series of interpretative phenomenological analysis cycles [26]. The aim was to explore how participants perceived each other's viewpoints and how mutual agreement took shape during the conversations. All researchers began by deductively coding the values and norms that appeared in the transcripts. These codes were then organized and grouped into broader categories when possible. In the next stage, three researchers (EL, NH, FV) reviewed the transcripts again and, through an inductive lens, traced how the codes shifted across the dialogues to understand the development of normative positions. Particular focus was placed on strongly critical perspectives, because they most clearly showed which values participants felt were morally threatened or undermined, and how they drew lessons from the situation.

Results and Discussion

Thirty interviews were conducted: nine in the northern and eastern part of the Netherlands, eight in the southern Netherlands, and thirteen in Flanders. 19 interviews involved residents and close relatives together, and 11 were conducted individually (7 with residents and 4 with close relatives). Residents were living at psychogeriatric, somatic, or combined units of nursing homes and ranged in age from 57 to 101 years (7 males and 23 females). Eleven residents had been infected with COVID-19. Close relatives included 12 daughters, 7 partners, 2 sons, a daughter-in-law, and a brother. Ten volunteers (aged 59 to 76 years, 2 males and 8 females, with 2 to 14 years of volunteer work in nursing homes) participated in the focus group. In the Socratic dialogue meetings, 5 close relatives (3 partners, 1 daughter-in-law, 1 daughter), two residents, and six volunteers participated.

First, we present the moral perspective on how participants experienced the restrictions in nursing homes and the extent to which they were critically judged. Second, we zoom in to examine which values and norms participants found most important and why. Third, we present normative lessons formulated by the participants based on their experiences with the restrictions.

Moral attitudes regarding the restrictions in nursing homes

In hindsight, most participants displayed quite balanced and thoughtful moral evaluations of the strict COVID-19 rules introduced in nursing homes. While they described the complete ban on physical visits as very difficult (i.e., triggering many negative feelings such as worry, frustration, fear, boredom, and loneliness), they did not label the early pandemic measures as morally unacceptable. They explained that they had initially gone along with the restrictions because the situation was completely unknown and unpredictable. Over time, however, several participants began to feel uneasy about the rules and started to voice critical moral opinions.

"It was…everyone is willing to make a sacrifice, my mother as well. So at the beginning it was all going pretty well. But at a certain point that ends. For us too, we were like 'oh, come on'!" (GH3).

Critical perspectives

Even though many participants ultimately accepted the measures in hindsight, they still raised clear objections to the ban on in-person visits. These objections are useful because they highlight which values are felt to be morally strained. In the sections below, we outline the main criticisms and the reasoning behind them — that the restrictions were disproportionate, unfair, and/or wrongly applied.

Restrictions experienced as disproportional

Some participants maintained that the rules did not adequately protect residents, as the virus continued to circulate in nursing homes. They therefore considered the original protection-based justification for the ban on visits to be invalid in retrospect. Participants also pointed out several rules that seemed contradictory or illogical. For instance, residents were permitted to attend group services in churches, yet family visits were forbidden. Another case involved a family member watching from outside as a staff member put an arm around a resident for comfort without respecting distance rules.

During the Socratic dialogue meetings, participants worked toward finding a reasonable balance between the benefits and drawbacks of the restrictions. They compared the harm suffered by residents and their relatives (e.g., loneliness, anxiety) with the intended aims of the measures (e.g., safety and protection). They frequently used strong metaphors — such as prison or war — to convey how heavy the restrictions felt. In the end, these participants concluded that the cost residents paid for safety had probably been too high, particularly because complete protection was never achieved.

"In a phone call, a resident said "someone in prison is better off than us, because then you are allowed to walk outside for an hour at the courtyard, while we aren't even allowed to leave our room". (focus group with volunteers R8)."

Restrictions are experienced as unfair

Another key criticism focused on the inconsistency in who was permitted to continue providing care in nursing homes during the lockdown. Rules differed from one facility to another regarding whether volunteers could continue their activities. Those volunteers who were still allowed inside felt uneasy because they could enter the building while family members were barred. They acknowledged that it helped residents to have at least some volunteers supporting their daily life and wellbeing. At the same time, they felt guilty and uncomfortable toward the excluded relatives, seeing the arrangement as deeply unfair. One care organization eventually suspended its entire volunteer program because of this issue:

"Eventually they decided: we are pausing the volunteers too, since we cannot reasonably defend banning family visits while still letting volunteers spend time with residents." (Focus group with volunteers R6).

Residents and their close relatives often described feeling discriminated against, as they did not influence these decisions. Many experienced a sense of powerlessness. Some family members were also upset at being labeled simply as "visitors," particularly when they had long been actively involved in the hands-on care of their loved one. One partner found it especially degrading that he — as a spouse — was suddenly treated as a mere visitor, even though he performed far more daily care tasks for his wife than the professional staff. He also felt it was unjust because he believed he posed a lower infection risk than the care workers.

"Yes, well, how shall I put it. I strongly disagreed. I helped her with everything every single day, and suddenly I was pushed aside as if I were a threat. Yet I believe that if I had been allowed in, the infection risk would actually have been much lower, since normally six or more different caretakers come in and out during the day. If it had just been me, the risk would have been far smaller, in my view." (T5).

Restrictions experienced as not rightfully imposed

A third area of criticism concerned the actual implementation of the restrictions across different elderly care organizations. Participants noticed significant differences in how the rules were applied between nursing homes. In some homes, residents were required to remain in their rooms at all times, whereas in others they were still allowed to go outside. Communication also varied greatly. Residents and families frequently noted a lack of clear, timely information from their nursing homes about what was permitted and what was not. As regulations kept changing, many close relatives were unsure which rules applied at any given time. Moreover, families often found it difficult to reach the organization and received little or no information either about the restrictions or about the condition of their loved one. This situation intensified their anxiety and frustration. They felt their difficult position was neither understood nor respected. Such inconsistencies created a strong sense of unfairness, since the treatment a resident and their family received depended heavily on which nursing home they were associated with.

Values and norms are recognized as important

In the interviews and focus groups, participants were asked which values had been undermined by the restrictions. Their critical arguments also made clear what they saw as truly valuable and morally significant.

These insights shaped the Socratic dialogue meetings, where the group explored how those values could be put into practice in everyday care — in other words, which rules, routines, and behaviors would be appropriate. Essentially, they discussed what norms should accompany these core values.

Safety

Everyone involved agreed that the safety and protection of residents was of great importance. However, opinions differed on how best to achieve this in daily life. Many believed that close relatives and volunteers who have few social contacts outside the home should be allowed to visit. Their potential to transmit COVID-19 was viewed as lower than that of care professionals, who typically live with several other household members. In short, family members and volunteers were not seen as posing the same threat to safety as staff.

Mental well-being

Apart from safety, close relatives and volunteers repeatedly highlighted residents' mental wellbeing as another vital consideration. They stressed that staying connected with loved ones should be regarded as a basic standard. Regular social and physical contact from family and volunteers could greatly reduce loneliness for many residents. One volunteer shared how painful it felt not to be allowed to see the resident she supported. Because of the resident's condition, video calls were not an option:

"She was already confined to her chair, unable to do much, and had to remain in her room. She didn't even see other residents anymore, so the whole situation was terrible. (…) I felt it was awful for her." (V1).

The mental wellbeing of the close relatives themselves was also mentioned as important. For some — particularly partners who had been used to daily contact — being unable to visit their loved one had a serious negative effect on their own emotional health.

Respect and recognition

Participants felt that people living in nursing homes were not given the respect and recognition they deserved. Residents and their families believed they were being treated unfairly because they had to obey much harsher rules than people living independently in the community. Residents frequently likened their situation to life in prison, as they were not allowed to leave the building or even step outside their rooms. Another major source of feeling disrespected was the lack of a voice in the decisions that led to these restrictions. Many described the sense that society had overlooked nursing home residents, viewing them as insignificant or no longer important.

"[And for you, what do you remember most if you think about the first months of the corona period?]

The strongest memory is the anger that no one truly listened to older people. When it came to easing restrictions, everything was justified by economic reasons. But for the elderly, there was nothing — they were completely ignored as a group." (L11).

Hope

Another core value mentioned was the importance of maintaining hope for brighter days ahead. Participants explained that they suffered from the complete lack of any outlook on when the visitor ban might finally be lifted. The ongoing uncertainty about its duration made the whole experience far more difficult.

"Then I think: if you know that it's only for two weeks, you can say to her: only two weeks without visits, we will call and Skype every day, and in two weeks we're allowed back in to visit you. That's also unusual, but now we didn't even know how long it would last. And it lasted and lasted, that was horrible". (GT1).

Moral lessons and recommendations

During the interviews, the volunteer focus group, and the Socratic dialogue meetings, participants were asked what key moral lessons they had drawn and what should guide future pandemic responses. Views differed, and people carefully weighed the strengths and weaknesses of different ideas. The three normative lessons considered most important by the participants are described below.

Tailored (well-balanced) solutions in context

Participants stressed that both safety and the need for social and physical contact with loved ones or volunteers are essential for residents' wellbeing. They recommended that emergency policies should be flexible enough to relax restrictions when a resident's mental or emotional health is seriously at risk. Where clear suffering exists, individual exceptions should be possible to honor personal needs and preserve human dignity. In general, they advised that every resident should have access to at least one dedicated close relative, or a volunteer if no family is available.

"Of course, every nursing home is different, and situations vary, but I believe you should always let at

least one special person in. That way, the resident always has someone they feel truly comfortable with. It's completely different from contact with staff. The staff is great, but being with someone you know and love is better." (T8).

However, the Socratic dialogue meetings also highlighted this approach as a moral dilemma, since allowing even one relative or volunteer per resident could endanger overall safety. Not every family follows safety protocols carefully, which could harm the larger group.

"That is actually a problem. There are many people who are very careful, but others do not believe in safety policies. They do not want to wear masks or wash hands, because they think it is bullshit". (SD2:R1).

The ability to adjust rules for urgent individual cases was seen as the fairest way to honor all important values, acknowledge people's suffering, and reach balanced decisions.

Proper recognition

A second major moral lesson was that close relatives who actively help care for the resident should never be classified merely as "visitors." Participants argued that family caregivers deserve real acknowledgment for their contributions. The label "visitor" failed to reflect the substantial daily care work that many relatives and volunteers already carried out. One husband described how he was suddenly excluded from his role as a care partner:

"I think there's a big difference between visitors and relatives who are also caretakers. It was all lumped together (…) All of a sudden you're no longer part of it". (SD3:R4).

Responsive power distribution

Following the previous recommendations, participants identified a third key moral lesson: nursing homes should receive greater authority from the government to create flexible, individualized policies that respond to the specific needs and wishes of residents, close relatives, and volunteers. Nursing homes should also focus on delivering clear information and maintaining continuous dialogue with all parties involved. In the Socratic dialogue meetings, participants clarified that they did not necessarily demand the final say, but they strongly wished to be heard and included in decision-making. The most crucial element was regular, transparent contact from the nursing home. This included receiving understandable updates about the current situation and any policy changes. Being taken seriously and properly recognized also meant having easy access to staff for support and reassurance when worries arose. However, giving non-professionals the ultimate decision-making power was viewed as a moral dilemma, since it might endanger resident safety. Participants noted that views among residents, families, and volunteers can differ widely, making consensus difficult. They felt it was more suitable for professionals to retain final responsibility, given their greater expertise:

"I think you should be a professional as it requires medical knowledge. I believe the discussion is already very complex, so we [family/volunteers] should not complicate it any further" (SD1, R4).

Although most participants initially showed understanding and accepted the restrictions, critical views gradually emerged. These criticisms addressed the effectiveness of the measures, their proportionality, perceived unfairness, and the manner of their introduction. The restrictions undermined several important values. When reflecting on the value of maintaining close relationships, participants highlighted (physical) safety and the mental wellbeing of both residents and close relatives as the top priorities. They also emphasized the need to respect and recognize residents and families, and to preserve hope. Participants formulated three central moral lessons for any future similar crisis: (1) policies should allow for tailored, well-balanced solutions in real-life situations; (2) close relatives should receive proper recognition for their role in care; and (3) power distribution should be responsive and inclusive.

Examining these moral dynamics through the eyes of residents, close relatives, and volunteers reveals patterns that align with established moral theories. First, the initial acceptance of restrictions aligns with Baier's moral philosophy [27]. Baier argues that trust in others' decisions is vital in situations of vulnerability and dependence on care. When facing new uncertainties or dependencies, people generally respond with compliance — they tend to wait and see, giving authorities the benefit of the doubt, especially when much remains unknown. According to Baier, this trust must be earned over time. If it is not, distrust grows, leading to more critical attitudes and frustration. This process closely matches the experiences described by participants.

Second, the moral epistemology developed by Margaret Urban Walker [28] helps explain how critical perspectives emerged over time. Walker views morality

as a collaborative social practice rooted in everyday life. Moral knowledge is built collectively through interactions: people learn from one another what truly matters and why. This does not mean everyone will always agree — different backgrounds and responsibilities often create moral tensions or ambiguities. Morality, seen as shared interpersonal understanding, is always evolving [29]. Critical perspectives serve as important tools for questioning whether current practices are truly the best for living together under specific conditions. The participants' criticisms opened valuable space for dialogue and negotiation about appropriate policies. Expressing and acknowledging threatened values during the COVID-19 outbreak in nursing homes helps advance discussion on meaningful moral lessons. Walker stresses that including all stakeholders and ensuring transparency are essential for achieving better moral practices.

For future pandemic policies, we strongly recommend incorporating the moral lessons voiced by residents, close relatives, and volunteers. This approach aligns with the Convention on the Rights of Persons with Disabilities (CRPD), which states that no policy should be made without involving those affected by it [30]. Moral case deliberation could be particularly helpful for the first lesson—developing tailored, well-balanced solutions [31]. This structured method brings all relevant stakeholders together to address concrete moral dilemmas. For the second lesson of proper recognition, insights from moral repair could be valuable [32]. Greater attention should be given to the "counter-stories" of residents, families, and volunteers about their experiences during the restrictions. These stories can help restore the identity and visibility of groups whose perspectives were previously overlooked [33]. The broader research project translated its findings into a detailed illustration showing participants' lived experiences during the restrictions [17]. This cartoon is now used in nursing homes to encourage ongoing dialogue and reflection among stakeholders. For the third lesson — responsive power distribution — we advise building and maintaining trusting relationships between nursing homes and close relatives. In any future visitor ban, proactive, detailed information about the situation inside the home and the residents' wellbeing can help prevent anger and distrust. Being well-informed, combined with mindful recognition of those affected, supports better handling of restrictions [16].

By including participants from various regions on both sides of the Dutch-Belgian border, the study captured a wide range of moral attitudes among nursing home residents, close relatives, and volunteers. However, because specific social and cultural contexts shape moral views, a limitation is that the lessons identified here may not resonate with or be accepted by all members of these stakeholder groups. For instance, the gender distribution was not perfectly balanced, with more female participants. Since morality continues to develop over time, these lessons should not be seen as fixed or universally applicable to all residents, relatives, and volunteers. Instead, they serve as important points for reflection and discussion in future moral debates rather than definitive conclusions.

A further limitation is the exclusion of residents with severe dementia. Their cognitive challenges made it difficult for them to describe their experiences of the restrictions verbally. As a result, the study relied on accounts from close relatives and volunteers about how they believed their loved ones had been affected. These second-hand descriptions were limited by both physical separation and residents' cognitive impairments, making it hard to fully grasp the emotional impact on this particular group.

Conclusion

This study examined the retrospective perspectives of nursing home residents, close relatives, and volunteers on the COVID-19 restrictions. The findings point to three important moral lessons for future pandemic policies: tailored (well-balanced) solutions in context, proper recognition, and responsive power distribution ('nothing about us, without us'). These recommendations are especially valuable because they foreground the voices of stakeholders who were directly affected by the measures yet had little or no say in the decisions. Taking these perspectives seriously can enrich the ongoing discussion on developing ethically sound practices in nursing homes for future pandemics.

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