Developmental Psychology

Relocation Into Italian Residential Care Homes: A Qualitative Analysis of Decision and Choice: Psychological Implications and Consideration on Health

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The current literature on the geriatric population highlights that relocation into a healthcare facility is a crucial event in the existence of many older people and their families. Guilt, difficulties, concern and restlessness may characterise this transition and even accelerate the ageing process in some. However, the manner in which the decision to relocate is made and communicated has not been well investigated. The following study aims to explore how older residents experience the transition into a care home as well as how they experience their relationship with it and its clinicians, and what processes may determine their own sense of autonomy. The researchers used a qualitative method and conducted semi-structured interviews. Critical discourse analysis (CDA) was chosen as the tool for data analysis. Results showed that relocation into care homes is described as a passive and influenced choice. Further, the facility is described as a place that provides essential services to older people but also as a place where it is possible to maintain personalised relationships. Finally, the study discusses the implications of older people's mental representations not only on their lives but also on how their relatives, clinicians and society perceive them. This also extends to the implications on how services are organised and implemented.

Introduction

The relocation of older people into care homes is becoming an increasingly crucial aspect in the lives of the individuals involved, their families, and the community (Ellis & Rawson, 2015; Ferrand et al., 2014; Fry, 2000; Tse, 2007). The relocation into a care home is indeed a delicate transition. Nowadays, there is an increasing number of older people, with complex health and social care needs that are living in residential care homes (Dudman et al., 2018). The current challenge is to offer services allowing older people to "age well". This should include interventions to help people identify various means of social support, along with opportunities for engagement in novel and meaningful activities, such as those that facilitate a sense of "usefulness" (Reichstadt et al., 2010).

To begin to address this issue, the current study focused on residents' experiences of relocation into care home. As it will be discussed further below, this topic involves several areas of interest, such as politics (Bradshaw et al., 2012; Pulkki & Tynkkynen, 2016), society (Marsden & Holmes, 2014), health service organisation (Ellis & Rawson, 2015), social and private life (Brownie et al., 2014; Kang et al., 2019).

From a political point of view, older people are often labelled as the social class of "the weak", who are inevitably in need of care (Gilleard & Higgs, 2013; Pulkki & Tynkkynen, 2016). Access to care homes is indeed assessed based on the "frailty" of older people, which is intended as physical weakness brought on because of a health condition – often disregarding the fact that an individual's vulnerability also depends on their ability to cope (Schröder-Butterfill & Marianti, 2006). As a matter of fact, from the older person's point of view, accepting the relocation into a care home means accepting the "needy person" stereotype, of someone who is "close to death" (Shippee, 2009). This often results in the older person feeling they are weaker than they are (Grenier, 2007).

Such a narrative around older adults is widely popular among social workers and healthcare professionals. Given the "paternalistic" nature of the way in which care is structured, the priority is given to the resident's physical integrity rather than to accommodating their preferences, wishes, and social needs (Kang et al., 2019; Lepore et al., 2018). Furthermore, as described by Olaison (2010), in their medical records, the older person is not introduced along

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with their personal history but with a description of their medical and physical needs. This culture utilises forms of communication that are unilateral, prescriptive, and imperative, characterised by patronising tones – all of which are typical of a relational model that makes older people feel treated like children, like they are not independent and lack the right to self-determination (Marsden & Holmes, 2014).

Similarly, the literature defines "institutionalisation" as a type of care home relocation (Bradshaw et al., 2012), in which care is undermined by organisational shortcomings, such as an insufficient number of staff and a culture that promotes "dependency". The completion of staff's daily tasks is at the expense of the residents' possibility to be involved in chosen leisure activities. (Fitzpatrick & Tzouvara, 2018; McGilton & Boscart, 2007; Sherwin & Winsby, 2010). As seen in Ellis and Rawson (2015), nurses and personal care assistants claim not to have the time to properly be involved into the moving phase of new residents, which creates barriers in building relationships with them (Coughlan & Ward, 2007; Heath, 2010).

The literature surrounding this topic broadly demonstrates that the need for interpersonal relationships is greatly underestimated (Alemán, 2001; Roberts, 2018). In line with this, some authors have found that care home staff ignore or interrupt social interactions with those residents who show autonomy in their care plan. In order to receive more feedback of relational nature, the same residents, however, end up doubting their own independence (Baltes, 1996; Brotman, 2003). For this reason, residents with better health experience a greater need to socialise compared to older adults who define their health condition as "unstable", and all of them – if asked to describe their condition – give a higher number of negative descriptions, compared to older adults living at their domicile (Antonelli et al., 2000; Custers et al., 2012). Due to these aspects, relocation into a care home appears to be a defining moment when older people have to deal with multiple and delicate issues.

According to some studies, during this transition, the older person can endure some negative experiences, especially when they are admitted to a care home against their will. This includes discontinuity with their own life experience, lack of independence and autonomy, lack of privacy and of a role to fulfil (Brownie et al., 2014; Fitzpatrick & Tzouvara, 2018), confused states, sense of bewilderment, restlessness, and issues in forming healthy relationships (Vigorelli, 2012). Contrary to this, by embracing the relocation, older adults experience a less traumatic loss of independence, both in terms of making their own choices and of undertaking simple tasks (Bradshaw et al., 2012). Moreover, the literature (Bangerter et al., 2017; Brownie et al., 2014; G. E. Lee, 2010) shows that the process of adjustment to the care home is better when the older person's expectations are met and some of their care preferences – such as choosing their personal doctor and place of care – are accommodated (Nguyen Thi et al., 2002; Schmittdiel et al., 1997).

Therefore, studying the way the decision of relocating an older adult into a care home is made appears crucial, as the outcomes can vary depending on how this process is managed.

The type of residential relocation being studied relates to relocation for reasons of health (Bharucha et al., 2004; Miller & Weissert, 2000), reduced autonomy (Enz et al., 2016; Hallberg & Lagergren, 2009; Miller & Weissert, 2000) or overwhelming frailty (Bloem et al., 2008; Puts et al., 2005), all of which are accumulated by needing care (Larsson et al., 2006). Thus, it is not about relocation for logistical reasons (Hansen & Gottschalk, 2006; Stimson & McCrea, 2004) or regarding home management issues (Sergeant & Ekerdt, 2008).

So far, very few investigations have been conducted into what older people think about this process and how they imagine the care home to be. The research questions that arise are the following: How is the decision of relocating made? Is the decision agreed on, or is it necessary to seek justifications to implement it? Who makes the decision? How is the solution presented?

The objective of the present research is to investigate the resident's experience of the relocation, the initial reception of social workers and the adjustment to life in the care home. The interest is particularly focused on life narratives according to the epistemological and theoretical framework of reference for this study, using the interactionist model, which studies the way in which suffering and unease arise through interaction.

In line with this, "Identity" and "Self" are conceptual constructs arising from interactions and relationships respectively. Identity constitutes an organisational structure of self-awareness and responds to the need for coherence and continuity. The Self is a product of the context, negotiated by taking the viewpoint of the other (Salvini, 2004). Therefore, the social and cultural context, where an individual lives and interacts with others, influences his or her self-representation. This self-perception, in turn, influences the way people are seen by others, in a never-ending cycle of mutual "influences" that become fixed over time. As a result, relocation into a care home seems to be a radical change in older people's life and to have repercussions on the ongoing building of Self and Identity.

Residential Care Homes in Italy

Residential care facilities in Italy are divided into two categories, in line with existing legislation and based on the degree of dependency of the users of the service. Care homes (*Case di Riposo*) are assisted living facilities for older adults who are partially self-sufficient. On the other hand, nursing homes (*Residenze Sanitarie Assistenziali, R.S.A.*) provide care and assistance to those who are not self-sufficient. The latter category has complex care needs, and therefore, nursing homes are equipped with more staff who are available for most of the day. Among the services provided by residential care facilities is social and health assistance, including helping residents with Activities of Daily Living (ADLs) to suit their basic human needs.

An individual is deemed not self-sufficient when, "presumably in a permanent way" (Resolution of the Venetian Region Council, Deliberazione Della Giunta Regionale (DGR) Ven. n. 1133 Del 06 Maggio 2008 "Scheda SVAMA: Profili e Livelli Di Intensità Assistenziale," 2008), they require assistance with washing, dressing, eating, going to the toilet, walking, moving. Though old people are dependent

Table 1. Demographics of participants

	Age	Self-sufficient participants	Not self-sufficient participants	Total
Female	65-75	1	1	
	75-85	1	2	
	85-95	6	6	18
	> 95	-	1	
	Total	8	10	
Male	65-75	2	2	
	75-85	-	4	
	85-95	2	2	13
	> 95	1	-	
	Total	5	8	
	Total	13	18	31

on others for their care, this does not mean they also depend on others for personal life choices. If a person is not able to care for their own needs or has totally or partially decreased mental capacity (articles no. 415 and no. 416 of the Italian Civil Code), then, according to Italian law, shall the person be assisted respectively by a power of attorney (article 404 of the Italian Civil Code) or a legal guardian.

Self-sufficient adults discuss their transition to residential care directly with the facility staff. The non-self-sufficient, on the other hand, access the facility after their needs' assessment. Usually, this is done by the Social Services through the council's Comprehensive Assessment Unit and the filling of the Comprehensive Geriatric Assessment (CGA) form (Deliberazione Della Giunta Regionale (DGR) Ven. n. 1133 Del 06 Maggio 2008 "Scheda SVAMA: Profili e Livelli Di Intensità Assistenziale," 2008). The score obtained from this assessment describes the applicant's incapacities and determines their placement in the Global Residency Ranking, who reach the first places are contacted by their chosen facility. There are no laws at the national or regional level defining a protocol for welcoming new residents. It is up to each facility to plan this moment ahead. However, uncertainty surrounding the ongoing update of the ranking and organisational issues do not allow a thorough "planning" of this stage.

Methodology

Design

The choice of adopting a qualitative approach was in line with the epistemological and theoretical layout of the interactionist perspective, as this is appropriate to recount an individual's personal history and their point of view (Flick, 2009). Research on people with "disabilities" or – as is the case – of older age is very often conducted through their caregivers, while, in our study, it was deemed necessary to engage with them (Iudici, 2015; Iudici & Fabbri, 2017; Ramcharan et al., 2004).

Participants

The participants are residents of an assisted living facility for older adults located in the province of Vicenza. The research project was originally presented to the facility's board of directors, who gave their consent to conduct the interviews. Residents were informed of the possibility to participate in the research by the researcher herself or by other professionals through word of mouth. Among the 120 residents, 31 people (13 men and 18 women), aged between 65 and 95, voluntarily agreed to take part in the research. See Table 1 for demographics of participants.

To be included, a cognitive profile corresponding to good mental capacity (in line with the CGA standards for the Venetian region) was necessary. This requirement should always be fulfilled as far as the self-sufficiency profile is concerned. The exclusion criterion was the presence of a diagnosis, or a state of poor cognition established by specialist neuropsychologists or psychiatrists.

Objective

Given the critical aspects previously presented, the aim was to investigate the following:

1. How does the older person configure the relocation into a residential care facility?
2. How does the older person configure the facility and its services, especially interactions and relations with its staff?
3. How does the older person perceive their autonomy living in a facility?

Tool: The Semi-structured Interview

The semi-structured interview is a data collection method that is typically used in qualitative research to acquire the interviewees' personal theories and beliefs (Cohen et al., 2004; Patton, 2005). Each question of the interview was developed by the researchers, based on the research objectives previously identified. They had the opportunity

Table 2. Interview Track

How did you decide to move from home to this facility?
What do you think about Residential Care Homes in general?
What do you think about this facility where you live?
Do you see any strengths in living in this Care Home?
Are there any aspects that you would improve, that in your opinion are not good enough?
How do the healthcare professionals interact and relate to you?
Have you identified a usual manner?
How would you describe your autonomy here, living in this facility?

to select the topics to be discussed (Corbetta, 2003; Fylan, 2005), the order in which these topics were discussed (Flick, 2009; Wengraf, 2001) and the way the questions were asked (Charmaz, 2004), while the interviewee was not constrained by a pre-determined type of answer (Pedon & Gnisci, 2004).

In an interactionist paradigm of inquiry, narrative constructs reality, giving it a very specific meaning depending on its context. Every individual needs to feel like an entity with intentions and goals, so they rethink their life events to be consistent with this view of themselves (Salvini, 2004; Turchi et al., 2019). The questions were identified based on the need to explore, from the perspective of the elderly, the delicate transition to a residential facility, how they recount this transition, and how they experience facility living, especially based on relationships and autonomy. This research question emerged from the international literature where there are few studies investigating the perspective of the elderly (Granbom et al., 2013; Larsson et al., 2006). The relational approach to interviews was based on co-construction processes through the interaction of both participants in the conversation (Gubrium et al., 2012). To avoid being the dominant party in this process, the interviewer's questions were based on a balance of involvement by both. The interviews were based on the interviewer's ability to listen, specifically to capture the meanings expressed by the interviewee. Throughout the interview, the interviewee was encouraged to expand their responses in order to encourage even more intimate expressions of their experience. The researcher used silence to allow the interviewee to complete their responses and to speak further. In interactive terms, the researcher also adopted open body language, assigning value to what the respondent said by nodding and smiling (Britten, 1999). The researcher further used reflection on the responses brought by the respondent and, in some cases, gently asked the respondent to clarify some unclear aspect of the response (Ann, 2017).

Data Collection

Prior to the interview, a brief introduction was given to inform the interviewees about the scope and the mode of the study. They were once again informed about the study and asked to sign the informed consent form for participation, anonymization of data collected, privacy, and recording. All interviews were conducted inside the residents' private bedroom or in a medical office and they were digitally tape recorded. They lasted on between 20 and 60 minutes.

Accordingly, interviews lasted 45 minutes on average.

Data analysis: Critical discourse analysis

Critical Discourse Analysis was chosen to analyse the data collected, which is an interdisciplinary approach to the study of discourse and aims at revealing the relationship between language, ideology, and power (Berring et al., 2015; Liu & Fang, 2016). The main reason behind this choice is epistemological: CDA is rooted in constructivism and understands that reality, as individuals experience it, arises from discourses (Baker et al., 2018; Harrè & Gillett, 1994). The real world is a set of social constructions, produced by language, and language and text create discourses in return (Bell et al., 2013; Harrè & Gillett, 1994; Jørgensen & Rendtorff, 2018). Therefore, analysing language, of which the discourse is composed, leads to the comprehension of the individual's reality. Moreover, discourses are located and contextualised, for they must be examined within the context they occur in (Edwards & Potter, 1992).

To perform the analysis, researchers examined the current literature about CDA in health care studies (Bell et al., 2013; Hakimnia et al., 2014; Joergensen & Praestegaard, 2018; Johansson et al., 2010; McIntyre et al., 2012; Pulkki & Tynkkynen, 2016) and referred to Van Dijk's socio-cognitive approach (2001), which is focused on three elements: discourse, cognition (individual and social cognition), and society (as face-to-face interaction, groups, group relations, institutions, and social and political systems). Moreover, the literature underlines that CDA is meant to shed some light on social problems, to understand the reproduction of social inequalities and the abuse of power, and to give voice to those, such as the older adults, who have none (Liu & Fang, 2016; Schofield et al., 2012).

In operational terms, the level of analysis chosen in the data collected had as its specific focus the way of signifying one's experience with the new residential facility, that is, the narrative positioning of the interviewees with respect to the process of transfer and the subsequent moments of life in the facility. This focus allows us to analyse the narrative positioning of the residents and what this means starting from our theoretical reference, which is how experience is constructed based on the lived interactions.

Data processing

All interviews were transcribed verbatim and read multiple times and the extracts that were relevant to the research

Table 3. Sample Discourse Analysis

Discourse Analysis	Text
Dimensions	Question: How did you decide to move from home to this facility? Answer: *"I couldn't be at home by myself anymore, my son found me lying on the floor and that's why I've been admitted to hospital, because of a stroke. Then my son didn't want me to stay at home alone, so he asked, and they gave me a place here to stay. [...] I was afraid of staying home alone and getting ill."*
Topic	The relocation is an immediate and inevitable process.
Local Meanings	*"She no longer wanted me to stay home alone and asked here"*. Focusing on the verb "want", we can understand that the respondent undergoes the transfer because it is another person who "wants" this to happen.
Formal structures	*"They gave me a place here to stay"*. The absence of the agent subject can be interpreted as a lack of knowledge of who made this transfer effective, again emphasizing that it was not the older person to make the decision.
Context	The choice of the term *"hospital"* also explicates the representation of the facility as a place for sick people, who need medical assistance.
Knowledge	*"I was afraid of staying home alone and getting ill"*. This sentence may tell us that the older person is not able to live alone also because of the prejudice that he is fragile and unable to handle daily tasks on his own.
Society	Starting from these elements, we may suppose a representation of our society as reducing the older residents' freedom of choice and a representation of them as sick people, who need assistance from others.

objectives were selected. After the selection, the transcriptions were broken down into sentences and they were grouped together (using coded meaning units, segments of texts that represent one idea or concept) according to the research objective they pertained to (Baker et al., 2018). These processes of collection and categorisation allowed researchers to identify some key elements. After having identified these semantic macrostructures (topics), which regroup the discourse's most important contents, researchers carried on with the analysis of local meanings, which is how contents are expressed. This process involved the analysis of grammar and vocabulary, e.g, jargon, metaphors, abbreviation (Berring et al., 2015; Van Dijk, 1995). analysis of "formal structures", which is the speakers' purposes and their perspectives on events discussed; context analysis, which is understood both as face-to-face interaction and as context where the experience takes place (cf. "Residential Care Homes in Italy"); analysis of the representation of the event at issue (Van Dijk, 1995, 2001). Finally, Van Dijk (2001) recommend the analysis of cognition, which is intended both as (1) personal, group, and cultural knowledge and (2) as attitudes and ideologies; analysis of the representation of society, which is determined by and, in turn, determines the discourse itself. Regarding this latest step, it was appropriate to analyse and reflect on power relations in policy formation, enactment, and implementation (Evans-Agnew et al., 2016). Starting from these elements a new interpretation of data was sought to establish new connections between the elements in question. This enabled new ways of understanding participants' responses. The categorisation and analysis were conducted independently by three researchers who discussed their findings and then reassessed the inconsistencies.

It is important to note that the discourse analysis was carried out on the transcription of the original interviews, which were conducted in Italian. The transcription of the manuscript into English was done at a later stage and reviewed then by four authors of the present paper for possible interpretation issues"

Results and Discussion

See Table 4 for Results and Participants' citations.

1. Relocation as a passively suffered and influenced choice

Relocation into a residential facility is described by a few respondents as an inevitable arrangement, given the impossibility to stay at home due to these needs: medical assistance, assistance with feeding, protection, and the need for company to combat loneliness "If I had no problems, I wouldn't be here. [...] Because when you are in need, you come here" (Participants No. 29). Respondents consider their relatives to be the real actors of this transition; in other words, they are those to whom the relocation decision is attributed. This decision is indeed taken in secret, not shared with the older adult, and originally imagined as a temporary relocation:

> At first, I was shocked. My daughter never mentioned it, she was talking only to her sister about it, but they never told me about their idea of taking me here. I had always thought I could go back home. (Part. No. 21)

Further, opposition and discomfort are often expressed regarding the relocation, along with the desire to stay at home "I couldn't stay at home alone, because I need someone, I need company [...] But I was fine at home too [...] but then I was thinking "What if something bad happens at night?" (Part. No. 11).

Even though many of the respondents are conscious of their difficulty, we perceive that most of their discourses are built in a passive form to represent a passively suffered decision. The following is an example:

Table 4. Results and participants' citations

Results	Citations
Relocation as a passively suffered and influenced choice	"At first, I was shocked. My daughter never mentioned it, she was talking only to her sister about it, but they never told me about their idea of taking me here. I had always thought I could go back home" (Part. N. 21)
The Residential Care Facility as an essential place for needy people	"When you are in need of care, you have to go where you can find it" (Part. N. 24)
The care facility as a dynamic and safe place	"I feel safe here because I see the nurses, they follow you and they are good" (Part. N. 10)
The Care Home as a place in which one can wish for a personalised relationship	"Well, they are a family to me, we get along well, they are like sisters" (Part. N. 1)
Autonomy as the possibility to make decisions for oneself	"Sometimes I would like to stay in bed, other times I would like to be up, it depends... We have to adapt to the way things are" (Part. N. 18)

> I couldn't be at home by myself anymore, my son found me lying on the floor and that's why I've been admitted to hospital, because of a stroke. Then my son didn't want me to stay at home alone, so he asked, and they gave me a place here to stay. [...] I was afraid of staying home alone and getting ill. (Part. No. 10)

In case the respondent claims they made the decision themselves, the choice always seems to be influenced by the desire to avoid creating problems for others. The aim is to avoid being bound by relatives or being a burden to them, as in the following case "I do not want to annoy anybody, I want to get by on my own, so I made this decision" (Part. No. 6).

In the interviews, most of these experiences are presented along with negative emotions "It's sad to come here, I can tell you... This is it, we need to accept it" (Part. No. 14). Boredom and tiredness are also connected with relocation and with life inside the facility "I'm not the one to decide. (This is) Boring, because time hangs heavy" (Part. No. 18) "There are moments, now, when I'm tired of staying here, of having to do what other people tell me to" (Part. No. 22).

Discussion

The conceptualisation of the older person as frail and weak does not seem to stem from real problems and difficulties expressed during the interviews but from needs attributed in a generic way and perhaps in a prejudicial way to old age and being old. These needs are perceived as the evidence of the impossibility to remain at home. Consequently, the relocation is conceived as inevitable. Indeed, accepting the need for help and the urgency to meet this need leads to the (forced) decision to relocate.

The older subjects can, therefore, feel that they have little control on their life and that they are no longer independent in their choices and autonomous in their everyday choices. All this can obviously have repercussions on their identity, as it is confirmed by literature (Bangerter et al., 2017; Grenier, 2007; Shippee, 2009). Having to accept dependency on others and their choices and, in these new terms, having to rebuild their identities and new relationships with the staff means that older people's experience is mostly sad. This sadness must be tolerated, and it seems hard, for respondents, not to experience it.

2. The Residential Care Facility as an essential place for needy people

Care homes are mainly conceived as a place for medical treatment, as a prison or as a "hospice". These definitions demonstrate that the care home is commonly thought of as a place where residents live the last few years in an apathetic, resigned, and lonely manner, waiting for their inescapable fate "I feel like I am in prison. Sometimes they come and pick me up, because they do some activities in the common room, then you can spend an hour of your time" (Part. No. 5).

Most of the respondents think about the facility as an essential service, which must be guaranteed for every person who is in need.

> I think that if care homes didn't exist, we would all be... Either you commit suicide, or I don't know what would happen to us. I think it's amazing that they have built places like this, because otherwise I don't know where we'd be now (Part. No. 19). This environment consolidates the image of residents as "needy" "When you are in need of care, you have to go where you can find it" (Part. No. 24).

In other instances, some of the interviewees claim that they "feel good" in this new accommodation, mostly because of the availability of healthcare. However, residents seem to feel good only if they have previously come to terms with the decision to be moved into assisted living, whether it is an active action or, more frequently, a passively suffered one.

> But I came here gladly, because when you can't manage to live on your own, you have to decide. I was alone, there was a carer who would come but just three or four times a week, for two or two and a half hours a day. So, I came here, and I am enjoying it. (Part. No. 7)

Accepting the relocation is linked to the acceptance of being "in need". Whether older people include themselves or not in the category of "needy people" may result in the acceptance (or lack thereof) of the transition into a place

where in-house staff can be perceived as "constantly" available to assist the resident. –But we have to settle for it. There are too little staff here, even the nurses are tired because they have to work too much, and they complain about it sometimes. They are all good at getting us out of bed, changing our clothes, doing stuff and, very quickly we're sorted. (Part. No. 17)

The facility is also described by means of comparison with something else. To elaborate, the facility is described in terms of what "it is not". A few respondents think of care homes as a useful service when they do not have children who can aid them "For people who have nothing, for older people with no kinds, who have nothing" (Part. No. 17). From these responses, we can implicitly understand the residents' expectations about their children. Frequently, in this process, there is an underlying belief that parents, who have taken care of their children, expect that their children would take care of them in return "I have asked my son if he could have me in his house, whether it would not have been possible I could have accepted the relocation into a facility" (Part. No. 8). The expectation of being assisted at home by children is at the risk of being let down and might provoke pain, especially when children do not think they are able to take care of their parents. In conclusion, if the decision to relocate into a facility has been made by the children, the most frequent scenario is that of a passively suffered transition, and hence, the mental representation of the care home is affected by the decision-maker's opinion "My daughter is happy, and she knows that I'm in a safe place here" (Part. No. 16).

Sometimes, the comparison with life at home, as a 'better place to stay', happens inexorably "I would really like to go back home. If it were for me, I would always want to go back home, but I just can't. That is the problem" (Part. No. 28).

The facility is also represented with a dichotomy when talking about autonomy: it is either a place where people must obey the rules or a place where they can still, to some extent, be free. The best thing was living at home. Your home is yours, it's you who decides what to do. Here I can't make my own decisions. They make them. [...] You must accept it. You can't change it; this is how the story goes. (Part. No. 23)

Discussion

The facility's representation as a place for "needy persons" puts older people in a position of need and subordination in relation to someone else – a role that, in this case, is adopted by care workers. Therefore, the representation of old adults as patient, as ill is quite understandable. In the literature (Shippee, 2009), we found that the relocation's awareness was followed by the acceptance of their being "needy" and "dying" persons and that visible signs of disability (walking aids) were stigmatised as a sign of their health declining (Iudici et al., 2019). The care worker is the one who spends most of the time with the resident because they directly deal with their assistance. However, in doing so, care workers risk replacing the older person entirely in their daily activities. Some of the residents perceive care workers as positive presences, especially when they

view themselves as frail and in need of help. Likewise, they do not feel recognised and feel negative emotions when staff, nurses, or doctors are not available. As highlighted by the current literature (Falk et al., 2013), overloaded nursing staff shows little engagement with the residents and waiting for assistance undermines the residents' sense of self and dignity as well as quality of live. Finally, it is important to underline the concepts of "perceived old-age" and "actual old-age", as there is a gap between the descriptions that older adults give about themselves and the descriptions they give about old age. The latter can begin even when one feels and thinks of him/herself as "old" because of one's characteristics and resources, and in relation to the context they belong to (De Beni & Borella, 2015).

3. The care facility as a dynamic and safe place

The most important aspects of residential care facilities that emerged from the interviews are the need for a sense of protection, the company of other residents, and the possibility of feeling autonomous about decisions "I feel safe here because I see the nurses, they follow you and they are good" (Part. No. 10). However, this is not so much about other people's physical presence as it is about knowing that there is someone to whom they can talk and from whom they can ask help "When someone calls for help, they don't leave them there alone. Even at night we just have to ring the bell that they are already in our room" (Part. No. 24).

Even other residents' presence at the facility holds meaning for respondents. "At least we can be in company with each other [...] If I stayed home, I would be alone [...] Here we have lunch together. It's a different life" (Part. No. 7). The need of movement and dynamism is understandable when respondents criticise the facility organisation, which promotes neither autonomous movement nor socialisation.

> This facility doesn't have an appropriate room where we easily meet, without asking the staff to help us go up and down, because this forces them to spend time they don't have. (I hope that) they have the chance to create a common room, at every level of this facility, where people can communicate as in a real community and not be left leaning against the wall. (Part. No. 9)

The chance to choose how to live their daily life is considered an important aspect by most of the respondents "They don't allow us to decide on our own. They impose us their decisions" (Part. No. 15).

Discussion

Another issue concerns the resident's representation of care home's guidelines and norms (especially those about freedom) and how this representation influences the relationship between residents and healthcare workers. Residents have stated that the facility's norms (particularly regarding its permissible and forbidden aspects) are ambiguous and inaccurate. This uncertainty can result in residents being confused about who, even on their behalf, makes the decisions about their daily living and their health care. Staff should ensure that individuals have information tailored to their circumstances to make decisions (Reichstadt et al., 2010). Consequently, some difficulties in trust-

ing and relying on others can emerge. From the residents' point of view, staff should treat them as competent adults and include them in the decision-making process instead of imposing choices about their health care (Schenk et al., 2013). Consequences on the relationship between them show that, to blindly follow the facility's norms and subsequently misread them, the care staff risk losing sight of every single individual's need (Koppitz et al., 2017). For example, the healthcare professional is often perceived as vigilant and attentive towards the residents (Schenk et al., 2013). This allows them to be ready to protect the resident, but also exposes them to the risk of being overprotective and limiting every action, such as allowing them to walk around alone, which is potentially dangerous. The old adult may be annoyed by this "over protection" and at risk of perceiving themselves as less autonomous than they might be. Koppitz et al. (2017) highlighted that, even though older residents had previously accomplished many of these activities on their own, they allowed these activities to fall outside their realm of responsibility. Residents may also believe that other people consider them to no longer be capable of performing certain activities.

4. The Care Home as a place in which one can wish for a personalised relationship

Respondents report that the number of healthcare workers is too small to meet their need for attention and the time spent talking. The staff is considered limited for the task of meeting the needs of the residents.

> We would chat more; I would like that. It's impossible to ask nurses for some time [...] They are always busy, they don't have downtime, as far as I can see [...] They need time for taking good care of patients (Part. No. 7). Furthermore, residents believe that the staff should know how to interact with them and how to accommodate their requests. In their relationship with the residents, healthcare workers should know "How to deal with them. To understand their character, to accommodate and to correct them, and not only to say "yes, yes, yes"" (Part. No. 6).

Understanding residents' "character" helps the staff meet their needs and even to realise whether these needs are not real. As the staff are qualified to do this job, residents show them respect not only as a sign of education but also as a sign of respect for their healthcare decisions "If she has studied to become a nurse, you have to respect her as a nurse [...] She must be respected" (Part. No. 4). On some occasions, the staff are said to lack in psychological training. This hinders the opportunity to understand the residents' real necessities "Psychological training for caring is missing in care homes. This is missing: the ability to understand patient's needs. A resident is really demanding for everything just because he feels abandoned, he feels alone" (Part. No. 9).

Respondents ask and particularly appreciate healthcare professionals' tendency to pay attention to their difficulties "Taking care of old people isn't so simple, there are older persons here who are not kind" (Part. No. 6). Frequently, staff members are represented as family members "Well, they are a family to me, we get along well, they are like sis-

ters" (Part. No. 1).

> This imitation of a familial bond allows them to feel the affection they would usually feel with peers and members of their family. I know some people here who arrives before their morning work shift starts and leave later in the evening just to come here and give me a kiss. What more could one want in life? I know that I'm loved. (Part. No. 26)

Older people have to rely on others, and it is due to these people's daily actions that they feel cared for. Care is, therefore, viewed both as healthcare and as being *looked after* "This place is totally human [...] this means that they get so much heart in what they do. We are here for being taken care and not only for being thrown away" (Part. No. 4).

Discussion

Regarding aspects that positively connote the facility's representation, it mostly cites the relationship with the facility's staff, other residents, and relatives. These relationships bring joy, and respondents propose solutions to nurture them, to create more opportunities for socialisation, by asking social workers for more time together and even to create common spaces where this can become possible. These results are coherent with the recent literature (Custers et al., 2012; Ferrand et al., 2014; Roberts, 2018) where it has been pointed out that meeting the need for relationships is the most important thing for residents.

Another aspect that should be considered is the possibility to experiment with an unequal relationship. When older residents have an equal relationship with a staff member and feel like they are "being ordered" to do certain things, they will not feel obliged to follow these orders, because of clashes in power dynamics. On some occasions, people experience frustration, hold grudges, and give rise to conflicts when an expectation based on their beliefs is not met. In their interviews, some respondents have admitted to calling for a staff member only to remind them of their presence and their power to be made to feel important and tended to at all times (Alemán, 2001).

5. Autonomy as the possibility to make decisions for oneself

What seems to be most important for the residents is the authority to make decisions about their lives' "I feel like I'm still at home, I do whatever I want. Nobody tells me anything" (Part. No. 8). It must be highlighted that the issue is not about the possibility of doing everything residents want to but about how they perceive this possibility. This means that even residents who are not very self-sufficient can peacefully live through their condition "After they're done sorting me out, I'm free" (Part. No. 26).

The possibility of doing what they are still able to do themselves, such as the task of taking care of themselves and dealing with certain responsibilities, allows them to still define themselves as active. This has consequences on their autonomy. Their relationship with staff members is at play in this process: they should not replace residents but only assist them.

> They gave me this place as self-sufficient because I'm good at dressing up, maybe I struggle a little, but if I need help, they do dress me up. If I can manage, I do it. But they can give me a bath and everything. (Part. No. 4)

Other important choices for residents concern simple everyday matters: for example, doing tasks they would at home, such as making the bed. The residents' lives can be strongly limited by the fact that they need help from the staff to get up, move around, eat, and take a bath. The most frequent reason reported about residents' difficulties is walking alone "I constantly need help, even for those little movements [...] I always need my walker" (Part. No. 2). It seems important to have the ability of going outside the facility.

> I really would like to go to church on Sunday mornings. My nephew comes and gets me but we can't go out of this care home. I'm allowed to go into the courtyard. That's fine. I sit there, but apart from this... (Part. No. 3)

However, it is not the actual ability of going out alone that is necessary to make residents feel autonomous but the meaning that the residents themselves attribute to this ability "I'm a little reluctant, they watch you, especially other residents [...]. I would be freer to go out, have a walk" (Part. No. 10).

If, on one hand, the room, accommodation, and assistance are parts of the facility's offered comforts, on the other hand, they might represent some limitations, possibly leading to conflicts between residents and staff members. What we want to point out is that some aspects of daily life inside the facility have become *so* habitual over time that the need to protect residents leads to staff members strongly limiting their freedom of choice "Well, you have to ask here, that's true. If I need something, I must ask for it" (Part. No. 29).

Conversely, the lack of freedom draws attention to the process of adjustment to life in care homes "Sometimes I would like to stay in bed, other times I would like to be up, it depends... We have to adapt to the way things are" (Part. No. 18).

The perception of no control on their daily life and of having to wait for staff members to meet their needs limits their perception of autonomy "They do decide the schedule, whether to go to bed at afternoon or not depends on them" (Part. No. 18).

Having the opportunity to do what they are still able to is part of how residents perceive autonomy. However, old people are reluctant about this. We can assume that realising they are no longer good at doing something can negatively influence the older person's perception of themselves as a "capable" adult.

Discussion

Making a comparison with the existing literature, our results are closer to what is pointed out in Kang et al. (2019), according to whom the relationship with healthcare workers influences the residents' perception of autonomy. Moreover, this perception plays a role in constructing residents'

"well-being" (Bradshaw et al., 2012; Ferrand et al., 2014). Although all health decisions are managed by the medical team, people have the right to know and speak about those decisions. This increases the possibility of building trusty relationships between residents and clinicians. On one hand, residents are aware of the importance of following norms and health guidelines. However, these norms and guidelines do not prevent them from knowing and making decisions about their life. On the other hand, clinicians cannot omit considering what is "good" for them. Thus, it seems very important for older persons to keep playing the central role in their days, lives, and society. Our results allow us to introduce the contribution of De Beni and Borella (2015), according to whom well-being and satisfaction do not seem to depend on how much control can be objectively exercised, on the ratio between the expectation of exercisable control and exercised control. Some residents can feel like they are still "useful", independent, and like they have a purpose in life if they are able to exercise their autonomy even if it is just in the activities, they believe to be still good at.

Conclusions

Relocation into healthcare facilities is currently considered by most of the participants as an inevitable, necessary and, most of all, passively suffered process that frequently represents a step towards the end of life (D. T. F. Lee et al., 2002). For many respondents, the relocation is the best solution to not disrupt their children's lives. This is representative of their idea of being someone who needs care that only care facilities can provide. Overall, it appears that dissatisfaction with facilities emerges from this dataset. The entire process of relocation seems painful, stressful and disrespectful of older adults' need and pace. This transition seems organised to meet families' requirements instead of those of the older person.

Nevertheless, healthcare workers and their assistance seem to be care homes' strengths (Falk et al., 2013), and hence, the facility is safer than residents' previous houses (D. T. F. Lee et al., 2002). This research clearly demonstrates the need of sociability: the presence of other residents and clinicians makes the facility a more familiar and hence brighter place (de Waard et al., 2018). The participants truly desire that some attention be paid to personal and relational aspects as confirmed by literature (Cipolletta et al., 2014; Ferrand et al., 2014). However, it seems that most of the healthcare professionals have limited time to spend on social activities and conversations, which are not considered a priority. Italian social stakeholders (clinicians, residents' relatives, facility administrators and managers of productive activities) have difficulties in perceiving of care homes as a place to live (as a part of the local community) as well as a place where care is provided.

Concerning the concept of autonomy, it has been shown that respondents, regardless of their effective ability, wish to make autonomous decisions and take responsibility for their choices, even those about the organisation of their daily life. A woman asserted in her interview, "I need to handle my own life" (Part. No. 5). However, the results show that this does not happen very frequently (Callaghan &

Towers, 2014). In fact, the clinicians' duty of protection and safety is often confused with the duty of custody, which leads to clinicians using a rigid and inquisitive approach. It is worth reflecting upon whether this representation of a "suffering" and needy older person unable to make decisions is useful for meeting residents' needs or rather for meeting the needs of their family, their society or the facility where they live. These results, echoing those of the current literature, confirm the need for guidelines and rules protecting older people from the risk of being submitted to others' needs. In addition, a lot of work remains to be done to reach an approach where the older person can be the actual "protagonist" of their own life (Reichstadt et al., 2010). This implies the chance for our society to challenge and change negative stereotypes about old age (Callaghan & Towers, 2014; Evans et al., 2015; Vines et al., 2015).

Prospects and implications for practice

Starting from our main results (relocation as a passively suffered and influenced choice and the facility as an essential place for needy people but also as a place for personalised relationships), this study has attempted to analyse their clinical, social and political meanings.

The results suggest a need for the rethinking and implementation of guidelines for care home admission. They should include relocation steps with practical and legal considerations. These should help healthcare workers and families encourage older adults to be protagonists of this process and encourage them see new possibilities instead of restriction. If the process is well taken care of, the move to the facility could be viewed as an opportunity rather than a painful transition.

Compared to other EU countries' experiences (Callaghan & Towers, 2014; Evans et al., 2015), it is hard to find Italian alternatives to care homes. There are a few co-housing experiences, which are apartment buildings where old people live in their own apartment but with a neighbourhood that can meet some of their needs. There are also some retirement villages, where the apartment is located inside a community that offers both basic services and healthcare services – medical assistance is always available. Improving these alternatives may be a better-balanced solution: the older person could live in a safe place but still be independent.

Finally, our results recommend social relationships to be the focus of the everyday routine. Simple interactions could be an occasion for building a wider and stronger sense of community. Practically, some considerations should be made about the possibility to hire more members of the staff (e.g. educators).

Going forward, our hope is that these considerations can be useful tools, both for clinicians and residents' families, to encourage older people to play active roles in their lives and the society. Moreover, this implies listening to them, their complaints and suggestions. A real change is needed to achieve this goal: our society should change the way it views older adults and reconstruct pre-existing beliefs, behaviours and interactions that have been concretised over time. Even change can be intended as a continuous dynamism: if interactions change, discourses will too, and at the same time, if mental representations and discourses change, methods of interaction and relationships will also follow.

Limitations

Limitations of this research concern the fact that all participants were from the same facility, therefore, results just have an explorative value. Regarding conducting interviews, answers may have been influenced by the researcher's explanation of the questions due to the respondents' lack of hearing or attention. Additionally, they may have been influenced by the idea they got about the interviewer. The researcher may, indeed, be perceived as a receptacle to their protests and complaints: for example, this could be about all the negative aspects of the facility. Further, discourse analysis allowed researchers to disengage from the contents reported during the interviews. Therefore, this interaction model, in the field of research, can be seen as a tool for older residents to make their voices heard. In addition, respondents may worry about what interviewers may think about them and, consequently, soften their opinions. Finally, it must be considered that all these oral answers have been produced through the dialect, as idiomatic form. Consequently, their transcription and translation into Italian may have removed the implicit meanings given by intonations, pauses, hesitations, and those conveyed by their way of speaking.

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Author Contributions

Antonio Iudici: Conceptualization, Methodology, Data curation, Writing; Chiara Verzelloni: Conceptualization, Investigation, Writing; Daniela Bonato: Concepualization, Analysis. Jessica Neri: Methodology, Reviewing and Editing; Elena Faccio: Methodology, Supervisor. Gianpiero Turchi: Methodology, Supervisor.

Competing Interests

All authors declare that they have no conflict of interest.

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All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Validation Ethics Committee University of Padua.

Informed Consent

Informed consent was obtained from all individual participants included in the study.

Data Accessibility Statement

All the stimuli, presentation materials, participant data, and analysis scripts can be found on this paper's project page on the https://osf.io/7aj6b/

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