Relational Social Work

# The impact of Covid-19 on residential care facilities: a national survey during the lockdown in Italy

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*Abstract*

*This article examines the impact of the Covid-19 crisis on residential care facilities for older people in Italy, using data collected through an online questionnaire administered to social workers during the lockdown.*
*The research had the aim of giving voice to the perspective of front line social workers, highlighting emerging challenges within the residential care settings, and the ways in which they tried to cope with them. During the first stage of the Covid-19 pandemic, several of the key determinants of care were under threat due to infection control measures, such as imposed visit restrictions and physical distancing. Social workers had to find new ways to support both residents and families, and guarantee constant information and active participation, in a context in which both residents and professionals were experiencing feelings of fear and uncertainty. The strategies to cope with such harsh circumstances described by the respondents show the key role that social work can play in the management of a health crisis in residential care settings. Social workers were able to provide socioemotional and relational care through meaning-enhancing activities and relationship-building, giving importance to the aspects of life that do not pertain to the technical practices for curing physical pathologies.*

*Keywords*

*Covid-19, disaster management, residential care, social work with older people, relational social work.*

## Introduction

This article examines the impact of the Covid-19 pandemic on residential care facilities for older people in Italy, using data collected through an online questionnaire administered to social workers during the lockdown.

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The research, promoted by the National Council of Social Workers and the National Foundation of Social Workers, had the aim to give voice to the perspective of front line social workers, addressing the following questions:

a) Which challenges the residential care social workers had to face?
b) Which was the impact of the health crisis on the lives of older persons in residential care settings?
c) How the social workers responded to the consequences of the Covid-19 crisis?

Italy was the second country in the world to be hit by the pandemic. Its timing and a lack of scientific knowledge about the virus determined a condition in which several variables were not under the full control of policymakers and decision-makers. Nevertheless, decades of studies on disaster management help to develop more complex analyses, highlighting the importance of actions for prevention and preparedness to mitigate the impact of a trigger event. The World Health Organization's Health Emergency Disaster Risk Management (EDRM) model refers to the systematic analysis and management of health risks, posed by emergencies and disasters. This framework indicates a combination of actions in different stages of the crisis management cycle, to prevent and mitigate risks, prepare the response and intervene with recovery measures (WHO, 2019). When a disaster occurs, the social conditions that affect vulnerability (Wisner et al, 2004) and its effects are already in place that will determine the possible outcomes or impact. The level of vulnerability may be influenced by the characteristics of individuals and communities that expose them to a higher level of risk. With regard to older people, the literature indicates the variables that may contribute to high vulnerability when a disaster strikes, such as low socioeconomic status, living alone, disability, chronic illness, and lack of an adequate support system (Bolin & Klenow, 1982-1983; Fernandez et al., 2002; Gibson, 2006). Also how the social and political system works has an impact on vulnerability, since it influences the allocation of resources, often linked to the distribution of wealth, power, and privileges within a given community.

Some of the most important developments in the understanding of disasters in recent years come from workers on the ground, in particular those in the frontline of disaster response, reflecting upon field conditions. Social workers, among others from the helping professions, can use their specialized skills in helping vulnerable populations in the context of disasters and learn from the experiences (Zakour, 2007).

Berkman et al. (2005) highlighted how skills for bio-phyco-social assessment, counseling, case management over the continuum of care, family practice and advocacy for the needs of older people are essential in the social workers' practice with older adults. Social work interventions and advocacy are also needed in designing policies and services for this population (Crampton, 2011). Various theoretical research studies have considered the important role of social work in institutional settings, with individual, family, group, or community interventions applied to the concrete aspects of caring for elderly people (Koren & Doron, 2005). Some authors analyzed how the role played by social workers

in nursing homes is influenced by the professional assumptions that orient their work, highlighting the gaps that exist between professional approaches that emphasize a more paternalistic concern and those that stress the independence of the aged, preserving autonomy and empowering the client (Koren & Doron, 2005; Cox, 2002).

Scholars have shown how in cases of disasters the social workers, including those working with older persons, can use their specialized skills in different stages of the emergency management cycle (Gillispie, 2013; Sanfelici e Mordeglia, 2020).

The starting point for this contribution is that social work practice is anchored in a broader organisational and socio-political context. Hence, this analysis intends to provide insights and lay foundations for wider professional debate about what types of interventions and action had demonstrated to be effective with older persons in residential settings, and which might yet be developed, in relation to social services in collective crises and particularly in a health crisis.

The first section of this article presents a brief analyses of the strengths and weaknesses of the health and social care services for older people in Italy, the impact of the Covid-19 pandemic on this population and the government's response. The second part analyzes the data gathered through our survey, highlighting the perspective of front line social workers on emerging challenges within the residential care settings and the ways in which they tried to cope with them. The relational perspective will guide the discussion about possible future directions and the role of social work in residential care settings in the context of a health crisis.

## The Italian services for long-term care in the pre-pandemic context

Italy is one of the countries with the oldest population in the world (OECD, 2019). Over the last two decades, gains in life expectancy and one of the lowest fertility rates have contributed to a rise in the share of the population aged 65 and over. In 2017, more than one in five Italians was older than 65 and life expectancy at age 65 reached nearly 21 years, one year above the EU average (OECD, 2019). As in other countries, Italians spend slightly more than half of these additional years of life with health issues and disabilities. In 2017, almost half of Italians aged 65 and over reported having at least one chronic disease, and one out of six reported limitations in basic activities of daily living, which may require intensive care assistance (OECD, 2019).

Population ageing has been exerting pressure on health and long-term care (LTC) systems, requiring increased efficiency through transformation of service models. However, despite the alarming estimates about demographic trends, long-term care policy in Italy is still struggling to be acknowledged as a relevant topic in the political agenda (Madama et al., 2019). The Italian public expenditure on long-term care appears in line with the average values of other European countries. However, Italian LTC public policies

are generally assessed as being largely unfit to address the specific demographic and social trends (Ranci & Pavolini, 2013), especially the social care component.

In Italy, there are four different main funding sources for LTC services: the Ministry of Health, for the healthcare system, the Ministry of Labour and Social Policies, for the social-care services, the National Institute of Social Security, for cash-for-care benefits, and regional and municipal authorities, for in-kind care services.

The Italian health system is characterised by a decentralised, regionally based National Health Service (NHS), that provides preventive services, primary care, specialist care and hospital care. The central government controls the distribution of tax revenue and defines a national statutory benefits package, the «essential levels of care». Each region is responsible for the organisation and delivery of health services through the Local Health Units and public and accredited private hospitals. According to the analysis provided by the OECD/European Observatory on Health Systems and Policies (OECD, 2019), the Italian health care system is generally efficient and performs well in providing good access to high-quality care at a relatively low cost, although there are significant variations across regions. Unmet needs for medical care in Italy are generally low, even if there are sizeable disparities in access to care across regions. In addition, a number of cost-containment measures have been taken in the wake of the 2008 financial crisis to reduce public spending, including the health system sector.

Italian social policies and social services have been described as a paradigmatic example of the southern welfare model (Ferrera, 1996). Care for dependent people's needs is mainly provided by family and intergenerational solidarities, while social services are structurally lacking, especially in the South. In particular, there is a high reliance on women to act as informal carers for children and people with long term-care needs. More recently, the unmet needs of European families have driven care migration flows, for non-EU and neo-EU workers, with a divergence from the typical familistic care model to a «migrant-in-the-family model» (Bettio et al., 2006). Law 328/2000 introduced the essential levels for social services. However, its implementation has not been supported by guaranteed resources (Leon & Pavolini, 2014) and undermined by the constitutional reform of 2001, which allocated the competence for social services to the regions and the municipalities.

The Italian LCT system is characterised by a strong focus on cash-for-care schemes and a relatively high degree of «decentralization» and «fragmentation» (Casanova et al., 2020). The decentralisation of the main policies and management of LTC functions to the regions allow them to define minimum standards of care and to choose different multidimensional assessment tools. This gives them a potentially strategic role to play for the promotion of innovation. However, some of the consequences are locally salient differences in the role of public and private actors, with a more collectivistic approach in some regions and a market-oriented model in others, with strong inequalities in care provision levels across the country (Casanova et al., 2020).

Moreover, authors have highlighted a progressive shift of LTC costs from the health systems to municipality social services and households, in order to tackle the pressure on health systems from the rising demand of care (Arlotti, 2015). This process has taken place through a progressive reduction of the length of stay in hospitals, the identification of stricter criteria for hospital admission for dependent elderly people, a transition to home care assistance, however mainly provided by families or informal care workers. This means for many dependent elderly people a shift from «a specific regulative system, like the health care sector (based on universalistic or insurance systems), to the social sector, mainly characterized by residualism, higher discretionality and extensive user's copayment» (Arlotti, 2015).

In addition, the reliance on unrestricted cash-benefits and the familialisation of care in Italy may have contributed to the lack of intermediate solutions, between informal assistance provided by families and full institutionalization of elderly in residential care (Madama et al., 2019). According to the National Institute of Statistics in Italy, residential care facilities active at 31st December 2015 were 12,828. 64 percent of all residential care beds were located in the regions of the North area, with a rate of 9 beds for every 1,000 residents (ISTAT, 2018). In the South area there were only 3 beds per thousand residents. The residential care recipients were 383 thousand. Around 288 thousand of them were elderly people aged 65 and over (75 percent). Three elderly recipients of four were aged over 80, and were mainly non independent and women. Among all foreign residential care recipients, 6 percent of all guests, only 3 percent were elderly.

Also, the national measure to support families through an unconditional cash-transfer has been shown to be ineffective in meeting the costs of care in the private market, for household with a medium-low income (Albertini & Pavolini, 2015; Luppi, 2018).

## The outbreak and the government response

Italy was the first western country to be affected by the Covid-19 pandemic. Even if what was happening in China in January showed the devastating effect of the virus, it was not considered that the pandemic outbreak would have been so sudden and extensive.

On 11 March, the World Health Organization (WHO) declared the Covid-19 pandemic. At that time, there were 118,000 reported cases, spanning 114 countries around the world, with over 4,000 fatalities. On the same date, the total number of cases in Italy was already 12,462, with 827 deaths (Ministry of Health, 2020a). In just two months, on 30 April, out of 2 million tests, the total number of detected cases was 205,463, mostly concentrated in the northern regions. Among those,1,694 were in intensive care, 18,149 hospitalised with symptoms, 81,708 in self-isolation at home, 75,945 healed and 27,967 dead (Ministry of Health, 2020b). Since the real number of total infections and deaths depends on the actual possibility of testing, the National Institute of Statistics analysed the

number of deaths, compared to the previous years. The most affected provinces by the epidemic recorded a three-digit percentage increase in deaths in March 2020, compared to 2015–2019 average (ISTAT, 2020).

Starting in March, hospitals in the North of Italy reported system saturation, due to very high patient loads requiring intensive care. One of the most afflicted areas was in the city of Bergamo. The shortage of hospital beds, ventilators and health professionals became a concrete threat (Nacoti et al., 2020). A major issue all over the country was the lack of tests and personal protection equipment to protect both people and health workers.

The Italian model to tackle the pandemic, despite its shortcomings as regard to preparedness, was characterized by the choice to quickly respond to safeguard the health as a priority, imposing severe generalized restrictions, given the available resources. The entire country has almost stopped for sixty days, with very heavy social and economic consequences, as happened in other countries of the world. On March 9th, a new decree established the creation of one single 'protection zone' for the entire national territory, with a series of strict containment measures for these territories: prohibition of leaving, suspension of all events, educational services and schools of all levels, museums and public offices, commercial and work/business activities with the exception of those that provide essential services. On March 17th, a shared protocol was signed, providing that production activities may continue only if adequate levels of protection were guaranteed to the workers. The agreement indicated the adoption of remote working, as much as possible. On March 22nd, a new decree established the interruption of all industrial or commercial production activities, except those listed in an attached list. The government also banned the movement or relocation of persons to a municipality other than the one in which they were located, except for justified work needs, extreme urgency or for health reasons.

Starting in March, the civil medical volunteers and other health care workers started to operate in the most affected regions. New hospitals were built and many had been converted into Covid-19 hospitals, with the help of NGOs and thousands of volunteers. In the beginning of April, the emergency response commissioner announced (Invitalia, 2020) that the intensive care beds almost doubled, those in departments for infection and respiratory diseases were four times more, and €13 million was invested to start new production of personal protective equipment.

However, during the first and acute stage of the pandemic there has been evidence of the weakness of community social and health services in the territory. This health crisis could be averted by adequate protection of health sector personnel, massive deployment of outreach services, home care and mobile clinics to avoid unnecessary movements and release pressure from hospitals, measures that unfortunately were not in place (Nacoti et al., 2020). In April, the national government approved the introduction of USCA (Special Continuity Assistance Units), to offer more specialised treatment for patients with no severe symptoms at home as soon as possible. Measures to enhance the capacity of testing and tracing, as well as to potentiate the health services at the territorial level, have

been introduced by the Relaunch Decree issued in May, including the recruitment of community nurses and social workers to provide integrated care on the territory. So far, only some regions implemented this measure, hiring dedicated nurses and social workers.

## The impact on older people in residential care

Although all age groups are at risk, the data available on Covid-19 shows how older people form a highly vulnerable group. Older persons are at a significantly higher risk of mortality and severe diseases following Covid-19 infection, with those over 80 years old dying at five times the average rate. In Italy, the mean age of patients dying due to SARS-CoV-2 infection was 80 years (Palmieri et al., 2020). The level of vulnerability is a function of the association of advanced age and number of pre-existing chronic diseases. 61.4 percent of the dead had three or more pathologies, 20.6 percent two and 14.0 percent one; 3.4 percent of the dead had no pathology other than coronavirus (Palmieri et al., 2020).

Older persons may also face age discrimination in decisions on medical care and life-saving therapies. The pandemic may also lead to the suspension of treatment unrelated to Covid-19, further increasing risks to the lives of older people (United Nation, 2020).

The spread of Covid-19 in residential care is taking a devastating toll on elderly's lives in several countries. Those in the residential care settings should have a particular attention, since they are the most exposed to the risk of contagion and death, given the higher average age and the fact that the vast majority are afflicted by one or more chronic diseases. The vast majority of them need help with everyday activities, a condition that implies close contact with care workers. In addition, it may be more difficult to respect physical distancing regulations, due to layout of the facilities and the arrangement of services and everyday life. In some homes older people share rooms and bathrooms, and during daytime residents join together in shared spaces for meals or recreational activities. Especially for people with cognitive impairment, complying with measures for physical distancing could be very difficult.

International data from nineteen countries show that the percentage of care home residents as a share of total deaths ranges from 24 percent in Hungary to 82 percent in Canada (Comas-Herrera et al., 2020).

In Italy, the National Institute of Health (ISS) analysed a subsample of 8,200 out of 88,517 cases to understand where the virus was more likely to be transmitted. Half of the cases (48.6%) were living in an old age home or in other residential services for people with disabilities. About 22 per cent of people became infected at home, 9.9 per cent in a hospital or in a medical office and 3.7 per cent at work (excluding health services workers) (National Institute of Health, 2020a).

In some European countries the primary focus was on hospitals, and governments immediately worked on these settings to postpone elective surgery, provide equipment, and organize mobile units. Residential care came to the public attention only later, and

this has cost lives (Declercq et al., 2020). Also in Italy several issues hampered the capacity to control the spread of the virus in residential care settings. The first guidelines for nursing homes were released after the country's total lockdown on March 9th, requiring to suspend visitations. Most of the regions issued the first guidelines for Covid-19 management a few days later (Berloto et al., 2020). The Lombardy Region acted on March 8th, though asking to the Local Health Units to identify nursing homes that met adequate structural and organizational requirements to host low intensity Covid-19 positive cases (Berloto, 2020), with the aim to improve the capacity of the health systems to face the lack of hospital beds. This decision was highly contrasted by care providers due to the high risk that such exposition could represent for workers and residents and was only poorly enacted. Italy faced an enormous shortage in masks and tests and the new PPE were primarily directed to acute hospitals.

In general, the delay in providing adequate measures and attention to nursing homes supports the conclusion of several authors about the fact that, despite its relevance, long term care does not represent a priority for policy makers at all levels (Berloto, 2020). This has created several vulnerabilities in the system, increasing the negative effect of the coronavirus.

In the following paragraphs data collected through a survey administered to Italian social workers during the lockdown will show the impact of this situation on the lives of older people and the work of professionals in residential care.

## Method

This research was promoted by the National Council of Social Workers and carried out by the National Foundation of Social Workers. A questionnaire was sent by email to all the Italian social workers members of the Council (n=42765), that is all registered social workers in Italy, obtaining a 48 per cent response rate. For our study, we analyzed a subsample of 16.615 professionals, those that declared to work as front line social workers at the moment of the questionnaire completion. A significant majority of the respondents self-identified as female: 94% in the total sample, and 95.4% in the subsample of workers employed in services for older people. This was a very similar rate to the one reported by the National Council (93.7 % female). Age groups from 31 to 40 (27.0%), from 41 to 50 (25.3%) and from 51 to 60 (23.9%) showed similar rates. 7.9% of the respondents were 60 years old or older, and 15.9% were 30 years old or younger.

Among professionals working in services for older people (n=2186), 671 were working in residential care centres. The present study focuses on this subsample.

The questionnaire included closed-end and four open-ended items; it was pretested with a group of 15 social workers and modified on the basis of their comments.

The data analysis was conducted using the steps of thematic analysis, as detailed by Braun and Clarke (2006). The data were coded in relation to how they answered the

research questions listed above. The themes were «identified within the explicit or surface meanings of the data, and the analysis [was] not looking for anything beyond what a participant has said or what [had] been written» (Braun & Clarke, 2006: 84). A theme was not determined based on a quantifiable measure, but rather «whether it capture[d] something important in relation to the overall research question» (Braun & Clarke, 2006: 82). The texts were read in full and initial ideas were noted. Then, initial codes were generated, reviewed and collated with similar codes into potential sub-themes; broader themes were refined by collating similar sub-themes.

The themes that emerged are presented in the following paragraphs, in relation to how they answered the research questions and are organized in four sections: (a) strengths and weaknesses within the organizations (b) ways of performing social work in an health emergency (c) the impact on residents and family members lives (d) social work interventions to tackle the emergency.

## Findings

### *Strengths and weaknesses with the residential care settings: unpreparedness and coping strategies*

In the first weeks of the emergency, one of the most frequently reported issues was the delay in testing for both the elderly and the personnel in the facilities. This condition had several consequences, increasing a sense of *confusion* and *fear* in the workers, the residents and their families. During April, testing started to be available; however, some respondents, especially those working in the most hit regions, highlighted how there was an insufficient number of workers to organize the shifts and guarantee the services, since many were in quarantine.

A frequently mentioned challenge was the necessity to deal with continuously changing indications and rules from the health authorities. Some social workers, employed as responsible or coordinator, reported the lack of timely, specific and concrete guidance from external health authorities on how to translate into practice general rules in the very first stage. Others reported to have taken decisions even before the formal announcement, with consequences and difficulties to communicate to residents and families.

Some of the respondents, mainly social workers not employed in positions of responsibility within the facility, reported a lack of integration between the health and social professionals, the latter not considered as essential and marginally involved in the first stage of the emergency. Other professionals referred to a lack of recognition of the role of social work in the facilities, with an exclusive focus on medical intervention.

Some respondents had the perception that their organization was stuck, responding only to the emergency, with an exclusive focus on issues related to physical health, neglecting the social needs of the residents.

> Not being able to see families and residents, the work of the social workers in the RSA (LSRCH) has been totally modified. We do not have any new admission. No visits. No team meetings. Only meetings to make decisions relative to the health emergency. The residents' needs are there as before, but it is very difficult to respond to them. People have the perception to have been abandoned and they need help in understanding the new situation.

On the contrary, other respondents described a prompt reaction of their organization. In particular, multidisciplinary teams were considered as strategic to discuss and make decisions on how to adapt the national and regional guidelines, in relation to the specific characteristics of their facility. Teamwork helped in feeling part of a common effort, in dealing with uncertainty, sharing strong feelings and difficult decisions, being together a point of reference for the residents and their families. Some respondents explicitly highlighted the importance of including every worker in the analysis of what works in responding to the emerging needs, to identify common issues, problems and their potential solutions.

> A best practice is to share and trace all the emerging issues, the solutions we have adopted and if they worked, and to share this with the direction, through a constant confrontation, useful to try solutions that are useful now, and can inform future decisions.

Two workers described how a course organized by an expert of emergency management helped in gaining the skills, useful to deal with this complex situation, and helped both the personnel and the residents in a competent way.

## *Different ways of performing social work during an health crisis: planning, improvising, retreating*

The way in which the social workers positioned themselves and reacted to the new harsh circumstances varied, influenced by organizational variables, the social workers' role and mandate in the facility, the geographical area, more or less hit by the pandemic, the impact of the emergency on them as persons involved.

In the majority of cases the social workers described how their role was to coordinate efforts, with the aim to respond to the social needs of residents and caregivers. Some of them explicitly talked about the mandate to develop a family and residents support plan as their main task. Some social workers were employed as responsible or coordinators of the centre, being able to interact directly with the direction in influencing the protocols and the programme to tackle the crisis.

Other respondents described instead a condition of total uncertainty and impossibility to plan for the future. «Living in the moment» was considered the best way, in a circumstance in which everything was changing too quickly, with a lack of evidence to make informed decisions.

> We live and work «in the moment», trying to manage everything in the best possible way. Until recently we didn't even have the swabs to understand exactly what was happening and how much the contagion was widespread, risking to undermine every action carried out.

For some of the professionals, working in an emergency meant first of all «being helpful» in any possible way, adapting and improvising, also taking on tasks different from those attributed to a social worker in ordinary times.

> Working in a «Covid-outbreak» nursing home, caseworkers are halved, so there are no more roles, we all have to work for the well-being of the elderly (...). I put myself on the front line, I have changed my role in this period, and my position in the office no longer exists. I'm always at the floors, actively contributing to help the elderly, also with hydration, recreational activities, and I help to support the workers more at risk of burn-out.

A few workers described a condition in which they felt stuck, experiencing feelings of fear and the necessity to take care of their own health. They were wondering if their work was essential at that stage, or if it was better for everyone to postpone some of their activities later.

> In our centre we are in the middle of the emergency, meaning that the residents and some employees have been infected. For this reason working remotely has been allowed, but it will not last very long, since they (the direction) want all the professionals to continue to be close to the residents. It is a time when there is a clash between the request of the direction (fulfilling in full the functions of a social worker) and individual needs for protection. I believe that from a prevention point of view, we should be granted the remote working that has been proved successful for most of the tasks linked to my role.

On the contrary, other respondents reported as an issue both the fact that their role as social workers was not fully considered by the direction and a limited understanding of what constitutes a comprehensive social work program in long-term care facilities. Some were asked to stay home on forced vacation, or to reduce their working hours.

> In the nursing home where I work, a crucial importance is attributed to health care activities. This choice is more than justified at this time. However, the choice to reduce the social worker's working hours underestimates the importance of the relationship based on trust, established with residents and family members. In my opinion, the social worker could strengthen these relationships, being supportive of the elderly and lightening the burden of care and health care staff.

## *The impact on elderly and family members' lives*

The majority of the respondents focused on the complexity of the task to avoid that the safety measures to contain the virus could turn into relationship restrictions, reducing personal choices and decision-making capacity.

Relationships between residents, their families, staff and the wider community have been described as fundamental to living a life of meaning for people in need of care. Relationality is fundamental, since relationships sculpt the being, doing, becoming and belonging of our existence (Edvardsson et a., 2020). Moreover, in residential care, translating into practice the concepts of autonomy, respect and dignity means that the residents are able to live their life and make choices subjectively, rather than based on institutional directives or others' definitions of health and wellbeing. Independently from the model of care the facility is oriented by, inevitably those who enter nursing homes face a significant reduction in the range of options available to them by virtue of the nature of institutionalized living itself (Boumans et al., 2005). The main concern of social work should be trying to foster communities within the facilities, guaranteeing to the elderly a choice in everyday activities, and promoting connections with the outside world by developing meaningful relationships in the living environment.

Most of the respondents described the difficulty of working in this direction, given the imposed disruptive change in routines and ways of interacting within and outside of the residential care centre. In the absence of means to test and trace, the best choice at the beginning was the isolation of people with symptoms, a new organisation of spaces, the suspension of many activities within the community and prohibiting contact with residents by anyone except medical professionals. No family members or friends were allowed to visit. Respondents highlighted the negative effect of visiting restrictions on both the residents and their families. The caregivers experienced worry and fear for the physical and emotional wellbeing of their relatives. The disruption of the routine triggered a range of emotional responses in the residents as well. Some were more able to cope, others expressed anxiety, frustration and sometimes angriness, also due to the uncertainty about when the restrictions would have been lifted. Others felt sadness and the perception of being «abandoned», having lost contact with all familiar faces.

The expression of affection from caseworkers and caregivers is normally communicated also through physical contact and closeness, that in the new context was limited as much as possible. In particular, for people with cognitive impairment, it was difficult to completely understand the new environment, the reason why their relatives were absent, and sometimes to recognize the staff that was wearing masks and gowns. During the lockdown, media coverage of the continuously increasing number of cases and deaths increased anxiety and sometimes a sense of powerlessness.

> The main issue for many residents is to understand what is really happening outside of the centre, while perceiving that everything inside is changing: lack of common activi-

ties, meals dispensed in the rooms, the fact that all the workers in contact with them are now faceless, without a facial mimicry, as they are covered by personal protection equipment. There is a lack of physical contact, the kind of relationship they always have been looking for. The affection of their family members is missing.

Working in an RSA (LSRCH) at this time, the biggest difficulty is managing the forced isolation that guests and families are experiencing, particularly for a residence that has never had time limits and has always worked with the family and the guest to build the care project together. The media reports provided about the residential care facilities put the family even more on the alert. Not having physical and visual contact penalizes the relationship a little bit, and we are trying to better manage these aspects through technologies and by strengthening the teamwork. Other issues are the physical detachment from their loved ones. Especially self-sufficient guests are forced to limit their movements within and outside of the centre, and this has reduced their autonomy in small things, such as shopping for the week.

Another frequently reported issue was the suspension of several administrative, social and health services, necessary to maintain the health and well-being of the residents. One social worker explicitly talked about «the right of not being considered as disposable», referring to the absence of services to diagnose the health issues and maybe to the risk of ageism in this stage of the emergency.

## *Social work interventions to tackle the emergency*

A common theme in the social workers' descriptions was the importance of providing accurate and updated information for family members about the wellbeing of their relatives, maintaining constant communication, and providing reassurance and counselling, mainly through technologies. Only a few respondents reported that the centre was not transparent about what was happening, with the information managed by the health staff only.

More and more I understand the importance of the support given through phone calls and videocalls with the caregivers. It allows proximity even at distance. It offers a moment to let go: to cry, to get angry, to thank and to share doubts. This is very important, because they feel that as a residential care, we are always present and we try to do everything for their loved ones.

Another frequently reported theme was the necessity to help the residents in making sense of the new situation and trying to build a «new kind of normality». In the majority of the answers is apparent the effort of the social workers to promote relationality, maximizing opportunities for residents to continue having options, choices and relationships, within and beyond their physical care. One of the main efforts was to facilitate daily contacts

and communications with their families, through the use of tablets and smartphones, that allowed them to see each other and reduce the sense of being at distance. Not all the caregivers had this possibility, so the professionals tried to organize visits, allowing residents and caregivers to see each other through the windows. A series of activities were reorganized to «mark the time» within the centre: discussing together the news in the morning, the moment for a coffee break, the possibility to maintain habits, like having their hair well fixed for Sunday with the help of the workers as hairdressers.

Some liaised with local schools and volunteers, using social media platforms to share stories, photos and videos, in order to promote external relationships in the midst of physical restrictions, and keep the connection with the community strong.

Some workers stressed the importance on involving the residents to imagine together a new routine, share their knowledge and talents with others, offering advice to the management of the response to the emerging issues, valuing their experience of historical hardship and resilience, that has much to offer in terms of guiding the way forward through the pandemic.

> The effort is to create a new routine that gives back certainties and marks the time, more than ever perceived as the worst enemy within the nursing homes. It is fundamental to actively involve the residents both in understanding and implementing together the new measures and reorganize the activities.

> As soon as possible, the facility has been equipped with tablets, that allowed daily videocalls between residents and families, showing the mutual needs to be reassured, to see each other, talk to each other and often let the emotions go, crying, smiling, looking... through a broadcast group, in the respect of the privacy, we regularly provided information about the evolution of the emergency in the centre and offered narration of the life within the facility, involving their loved ones. We tried to keep the relationship of trust that was «enshrined» when they entrusted their loved ones to the care of a residential centre.

## Discussion and conclusion: the role of social work in residential care facilities before and after a health crisis

The literature on disaster risk stresses the importance to focus not only on the physical vulnerability of older people during a crisis, but also on the relational dimension and the underlying causes of vulnerability, including the political, policy and organizational factors that increase risk exposure (WHO, 2019). Environmental protection, welfare state programs as well as the characteristics of the social networks in a territory can play a fundamental role against related disaster shocks; lives could be saved and costs lessened if people are better protected against basic social and environmental risks.

The social work functions in disaster intervention can be conceptualized, distinguishing three areas of activity: planning for disaster prevention and preparedness, acting to

mitigate the impact of a crisis, contributing to multidisciplinary analysis of emerging needs and planning in the reconstruction stage (Sanfelici e Mordeglia, 2020).

Our findings highlight few actions in the mitigation phase at various levels. In the first stage of the Covid-19 emergency, one of the more frequently reported issues by the social workers in nursing homes was related to the unpreparedness of the organization to protect the health and safety of both the workers and the residents in the context of a health crisis, due to the lack of PPE and sometimes the lack of clear guidance from the authorities. This finding is in line with the results of a survey conducted by the National Institute of Health, to investigate the Covid-19 spread and management in residential care centres. For three out of four of the respondents, the major difficulty encountered in the outbreak management was the lack of PPE, followed by the difficulty in isolating infected patients and weak guidelines from the authorities to limit the spread of the virus (National Institute of Health, 2020b). This condition led to several consequences for the physical and emotional health of both residents and professionals, and the necessity to rethink social work's tasks and tools to adequately respond to the emerging needs in a totally changed scenario.

Social work can play an important role in the pre-emergency stage, preparing both the residents and the workers to tackle the possible consequences of a health crisis and advocating for the needed resources.

Evidence that also emerged is the key role of social work in the management of the crisis in the response stage. Nursing homes are more likely to host residents who have lost physical or cognitive functions and need the help of caseworkers in activities of daily living. An exclusive focus on interventions to compensate for lost capacities can lead to mistaken presumptions about their level of competence and little space for attending to remaining levels of autonomy. In particular, a physical vulnerability model (Morris et al., 2018), that focuses on difficulties and disability from medical or charitable lens, may lead to stress individual deficiencies and needs only, with the risk to undermine the importance of the person's independence, preservation of autonomy, and empowerment. From the data emerges how some nursing homes seem to be more focused on addressing physical needs, with less consideration for the social dimensions. Such tendency can be contrasted with the adoption of a relational lens, that reminds the importance of the large part of life that does not pertain to the technical practices for curing pathologies (Folgheraiter, 2007; Raineri & Cabiati, 2016).

The data collected through the survey shows the efforts of the majority of the respondents to promote feelings of purpose and relationships in the lives of older people, despite the limitation imposed by the measures to contain the spread of the virus. Pre-existing relationships with family, as well as those with staff members and other residents, have been fundamental to make sense of the new situation collectively, sharing both negative and positive emotions, and supporting each other.

Shifting attention from strictly person-centered to a more relationship focused care leads to more creative interventions that consider the importance of the socio-emotional

aspect of life in residential facilities. Social workers, with their skills in networking and strength-based intervention, are well-positioned to facilitate this shift also in ordinary times. In the context of a health crisis their intervention has been essential in focusing the concern on all the aspects of life beyond the cure and prevention of the disease, within a collective sense-making process. A social worker explicitly recognized to have no competence in how to deal with a health emergency, but working with the residents and the staff gave her the strength to cope with the overall situation, highlighting how a helping relationship is reciprocal.

> My patients has given me the strength not to retreat from this pandemic. I had to be with them, I had to go to the facility every day and not abandon my team. I don't know how to deal with a pandemic and I can't give advice, but working with fragile people gave me the drive and motivation not to panic.

Some respondents also mentioned attempts to increase the pool of relational ties available to residents, even in a time in which «stay home» was the general prescription for everybody, creating connections with the external communities. This had the potential to offer a sort of socioemotional and relational care through meaning-enhancing activities and relationship-building. Promoting ties outside the facility can also contribute to challenge ageist assumption and collapse the social space between the residents and their wider community. Also in times of emergency, for social workers «the «social» (the part of society coping with a problem) can act as their ally in finding the solution» (Folgheraiter & Raineri, 2017:16). These professionals do not seek technically to repair a disaster, but they help in creating meaningful alternatives to evolve within a social context.

A social vulnerability perspective (Wisner et al., 2004) to disaster risk requires taking into account the analysis of wider socio-economic and political systems, which creates social inequalities along lines of age, gender, class, race and ability and, in turn, determine unequal access to resources and unequal exposure to risks. Such framework challenges the notion that disasters are intractable phenomena that cannot be prevented or mitigated (Priestley & Hemingway, 2007), highlighting how they are to varying degrees socially and politically produced (Morris et al, 2018; Pawar, 2008). One of the reason why residential homes had such difficulties in dealing with the outbreak is related to their place in the national health care and long term care systems. The Covid-19 crisis showed that, at least in the first stage, they were not a priority, in spite of their vulnerable population (Declercq et al., 2020).

The major lesson learned is that prevention is much more effective than curative measures to tackle the effect of a pandemic. Knowing the characteristics of the population in residential care as well as the features of the existing facilities and analysing the necessary changes to guarantee preparedness are needed. It is of utmost importance to invest in qualified staff, education, protocols, the necessary equipment and adequate layout and spaces. Pushing this to the top of the political agenda requires a change in our attitude

to older people, and an awareness of the ageism that has influenced policies, sometimes viewing them as major social problems, rather than as people who can provide a sense of wholeness or wisdom. A relational perspective implies to challenge these assumptions, promoting an anti-oppressive practice within and outside the residential care settings, contributing to explore the power relations preceding the social disaster construction.

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