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Elderly Care During the Pandemic and Its Future Transformation[1]

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Abstract

The research we are presenting is based on the following question: what happened inside the Residential Care Facilities and the nursing homes for the fragile and /or non-self-sufficient elderly, between the first COVID-19 case in Italy (21/02/2020) and the end of the lock-down (04/05/2020)?

In order to answer that question we conducted a qualitative exploratory research thanks to which we were able to get in touch with the nursing homes and better understand the resources they used, the obstacles they encountered and some innovations they put in place.

For the purpose of the study we collaborated with the Alberto Sordi Foundation. We involve 22 organisations coming from all the regions for two reasons: we were studying a healthcare system based on a regional model; the contagion spread differently in the various regions.

The conclusions are focused on three elements that should regard the future perspectives on elderly care models: 1) care, which, seen as fundamental right underlying the recognition of citizenship; 2) an experimental territorial governance; 3) the implementation of a new service profession called care manager.

Keywords: elderly care, pandemic, nursing homes.

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[1] The article is the result of the joint reflection of the two authors and so all the paragraphs were jointly authored.

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1. Introduction

The time and space dimension within which we develop the considerations regarding the study presented in this paper, are outlined by two images.

The first one, taken the night between the 18the and 19th March 2020, portrays 10 Italian military trucks slowly leaving Bergamo. They were carrying the bodies of the deceased to other cities to be cremated as the local facilities were not able to manage such high demand.

The second image portrays the first hug an 85-year-old woman receives in a nursing home, following months of isolation. A big plastic sheet stands between her and her family as they embrace. The picture won the 2021 World Press Photo of the year award.

These images recall a wartime scenario: military vehicles used as hearses to transport the deceased followed by an armistice and a family reunion. What transpired in the space that divides the two images?

Both images talk about death and isolation. According to the news broadcasted between April and June 2020, death and isolation describe the circumstances of the elderly living in nursing homes.

The media painted a horrifying picture of those facilities, describing them as true places of death. Places where a hidden massacre of voiceless men and women had taken place in those three months. The media stated that those men and women had been deported and abandoned and their right to life, health care and non- discrimination violated (Amnesty International 2020).

Infodemic became a frequently used word. It describes a situation where large quantities of often not thoroughly examined information spread rapidly. Therefore, finding reliable sources of valid information on a specific topic becomes extremely difficult.

In February 2020, during the COVID-19 spread of contagion (Vicarelli, Giarelli 2021). The World Health Organization used this neologism (infodemic) to highlight the fact that perhaps, the biggest danger of the global society in the social media era, is the distortion of reality through the echoes and the comments of the global community on real or often invented events1.

The aim of our paper is to understand what transpired inside nursing homes between 21st February 2020 and 4th May 2020. Our intention was to conduct a qualitative-exploratory research that would go beyond the mere description of the phenomenon through a death toll. We wanted to understand the organizational and relational mechanisms inside the nursing homes typical of the above interval.

[1] Leonardo Becchetti, Avvenire.it, 5 February 2020, Opinions

2. The topic of the study

As of today, in Italy data regarding the COVID-19 mortality rates inside nursing homes are neither certain not complete. The reason is that both in Italy and abroad there are currently three approaches to measuring deaths caused by Covid-19:

1. deceased tested positive (before or after they passes away); 2. deceased who were thought to have been positive due to their symptoms; 3. Excess deaths, meaning the comparison with the number of death during the same weeks in the years before.

The national research we currently have available (published on 5th May 2020) is a survey conducted by Istituto Superiore di Sanità (Superior Health Institute) (ISS 2020b) in various nursing homes. The survey was based on a questionnaire that was sent to

3,417 nursing homes and it registered the total amount of deaths between 1st February and 2th March 2020, meaning deceased who tested positive and those who had symptoms.

1,356 nursing homes took part in the survey (97,521 elderly nursing home residents) which amounts to a little over one-half of the nursing homes that had been contacted.

The total amount of deaths was 9,154. Out of these, 7.4% tested positive. If we add the deceased who had flu-like symptoms, the numbers rise to a little over 40% (Superior Health Institute) (ISS 2020b). Even though we are aware of the fact that we are dealing with incomplete and uncertain data, we can try to make a comparison on an international scale. If we project the ISS survey data on the total availability of the nursing homes, the total number of deceased (positive test + symptoms) amount to 11,192, which is 32.2% COVID-19 deaths in Italy (Istat 2020). On a global level, the numbers of COVID-19-related deaths in nursing homes are much higher and the same fluctuate between 25% (in Australia) and 67% (in Spain), with 60% in Norway, Ireland and Canada, 36% in Germany and the lowest, 19% in Belgium (ISS 2020a; WHO-Europe 2020).

In Italy, the average age of the deceased who were positive to COVID-19 is 80. 85.5% of the deceased were older than 70. Furthermore, the analysis of the clinical records highlighted the fact that these patients had other comorbidities (on average, they had 3.3 pathologies).

Dr. Pearesi (2020), the director of the National network for the non self-sufficient, following the analysis of the (little) data available, hypothesized that the total number of nursing home deaths was somewhere between 8,500 and 11,000. The COVID-19 -related deaths represent 2,9-3,8% of all nursing home resident deaths in Italy, and 24,5-31,7% of all COVID-19 -related deaths in the

country. These numbers are quite high yet below the European average (Comas-Herrera, et. al. 2020).

The mortality rate for COVID-19 of Italian over-70s was 0.2% (Istat 2020), this figure increases tenfold when we look at what happened inside nursing home, why did this happen?

Hans Kluge, the European OMS manager defined this phenomenon "a human tragedy of unimaginable proportions" (WHO-Europe 2020).

By nursing homes, we intend rehabilitation facilities intended for the elderly following a hospitalization and a serious illness.

According to the BES report (Istat 2019), in 2016 Italy had 12,501 residential public health and welfare facilities able to host 412,971 residents, i.e. 6,8 per 1000 inhabitants. The overall data shows regional imbalances with 9,6 slots per 1000 inhabitants in the north and 3,8 per 1000 in the south.

The description of the nursing homes can be further completed with data from the latest census conducted by Auser (2017) which states that over 70% of the residents are not self-sufficient, one third is under 80 years old, the average age in 80 (Arlotti, Ranci 2020a) and 74.6% of the residents are female.

As far as the business is concerned and the type of property, 36% are non-profit organizations, 25% are public, 22% are private and 15% are religious organizations. The sector employs 362,499 workers, 308,125 of which receive a salary while the rest are volunteers. The facilities have various capacity based of the regional guidelines. However, in order to have "economy of scale" benefits with respect to the management costs, both in terms of personnel and in terms of facilities, the general tendency is to have over 100 units (NNA 2020).

Albanesi (2020) in his report shows that the elderly often share rooms with a few other residents. This element is often highlighted as a positive one during the reception stage as it tackles the problem of loneliness. The ISS report states that the survey participants (1351) declared that in 48.1% of the cases they were able to isolate in a single room residents with COVID-19 symptoms, in 30.7% of the cases they were able to isolate the infected residents in dedicated rooms, while in 8% of the cases there was no possibility for isolation (ISS 2020b).

The data guide us towards an initial, perhaps commonplace answer regarding the elevated death rates in these facilities: if the elderly are more prone to getting COVID-19, if the death rates are high among the over 70 population, if the infection is highly contagious and maintaining a certain distance is advisable- then nursing homes, due to their characteristics, represent fertile ground for the diffusion of the virus and for the increase of the mortality rates (Istat 2020).

Various discussions have developed on specialized blogs over the last few months regarding this question and some have mentioned the "total institution" concept coined by the American sociologist Erving Goffman (2010) in

reference to nursing homes. That means nursing homes are places where the elderly are stripped of their identity and freedom and subjected to designed routines to contain the social deviance (Amnesty International 2020; Lupton 2021). In this case, the deviance is represented by their old age and the inability to perform a number of functions and roles. For that reason, the social system entrusts their care to others (people who are not family members). Those who use the total institution concept to stigmatize the organization and their work, call our attention to a nodal question of our social system i.e. the "setting aside" of individuals who are no longer productive in a specific social context.

These are surely the most spontaneous and immediate answers as to why the death rates inside nursing homes were so high (Petretto, Pili 2020).

There are still some unanswered questions regarding:

- The internal dynamics in these facilities (the relationship between the management and the staff and between the staff and the residents);
- The external dynamics (management-residents-families; healthcare institutions, local public administration etc.)

The aim of the study we carried out is to understand what happened inside the nursing homes during the initial phase of the COVID-19 pandemic emergency. We did not merely focus on the death rates but rather examined the changes that took place regarding the internal organization in terms of dynamics between the management and the workers, the resident health- care models, the relationship with the families and with external institutions.

A study conducted by the Social Politics Laboratory at the Polytechnic University of Milan defined the above phenomenon: "a hidden carnage" (Arlotti Ranci 2020b). Hidden because these facilities had not been given the means to ascertain whether the residents were positive or not, and to subsequently adopt isolation measures; hidden because the nursing home death rates data were kept out of the official statistics for quite a while; hidden because it was not monitored by professionals/policy makers able to intervene; hidden because it was kept out of the media for a long time.

What was happening inside the nursing homes probably remained concealed for weeks on end because, even prior to the pandemic, these facilities and their residents were invisible when it came to social innovation interventions. The situation inside these facilities for the fragile elderly paradoxically came to the surface thanks to individuals who are a link between that reality and the external world, namely the families. Having been denied the possibility to visit their relatives, or to see their laid out bodies and participate in the funerals, they started pressing charges. That brought the problem to the front pages of all newspapers and all newscasts (Arlotti, Ranci 2020a)

The fear and suspicion that an elderly member of the family may be abandoned by the staff (doctors, nurses, welfare operators, etc.) responsible for

his/her wellbeing, may render more delicate and difficult the relationship between the families and the staff (Colombo 2021).

That circumstance undermined one of the nursing homes cornerstones: the communication with the families. A communicative hyperbole pulled the problem out of the walls of these facilities and rendered it a collective problem.

3. Research methodology

The research we are presenting is based on the question we put forward in the previous paragraph: what happened inside the Residential Care Facilities and the nursing homes for the fragile and /or non-self-sufficient elderly, between the first COVID-19 case in Italy (21/92/2929) and the end of the lock-down (04/05/2020)?

In order to answer that question we conducted a qualitative exploratory research thanks to which we were able to get in touch with the nursing homes and better understand the resources they used, the obstacles they encountered and some innovations they put in place.

For the purpose of the study we collaborated with the Alberto Sordi Foundation with headquarters in Rome. The Foundation has been providing care and well-being for elderly since the 90s at the behest of its Founder.

The Alberto Sordi Foundation was selected because the 12th December 2018 it published the Alliance Charter (Carta Alleanza) for the elderly 2. The same was initialed by 60 organizations. The Charter focuses on care for the elderly through promotion of networks of caregivers throughout the country, personalization, co-design and design co-responsibility regarding services aimed at providing support for innovative projects for the elderly. The Charter defines its action field and 4 specific objectives based on the above principles:

1. research aimed at new economic, social and cultural sustainability systems in the field of welfare for the vulnerable elderly;
2. social advocacy for the elderly- representing the vulnerable elderly and their life contexts;
3. creation and promotion of networks involving multiple social actors throughout the country;
4. planning and implementation of research projects and innovative services.

This document and its endorsers provided us with a starting from which we could begin to explore the topic of the pandemic management inside nursing homes. We began with 10 facilities and later developed a non-probability

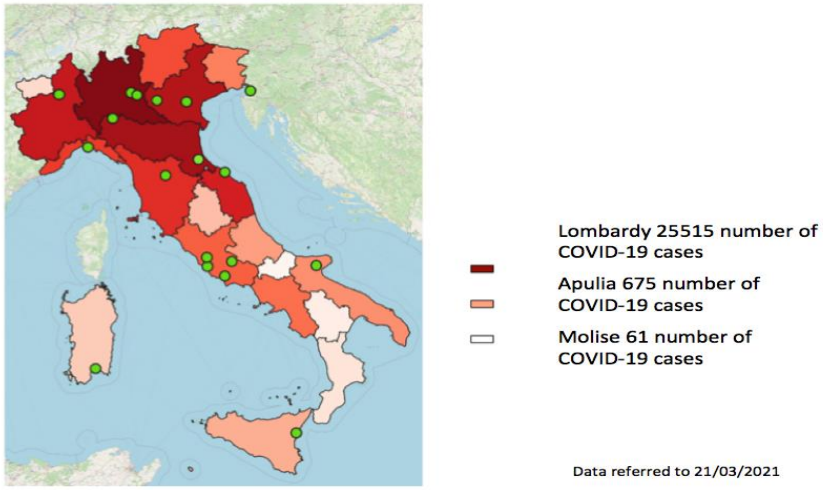
[2] https://www.fondazionealbertosordi.it/alleanza-per-le-persone-anziane/

"snowball" sample where we asked the individuals who had been involved in the study to provide us with names of colleagues who would be interested to participate.

Even though our sample was not statistically significant, we tried to involve all the regions for two reasons: we were studying a healthcare system based on a regional model; the contagion spread differently in the various regions.

21 facilities participated in the study and their distribution can be seen in the map below. The same contains the dimensions of the regions (hence various typed of coordination and healthcare institutions) as well as the diffusion of the virus (dated 21/03/2020).

FIGURE 1. Geolocation of the facilities involved in the research, per regions and COVID-19 diffusion.



The facilities that participated cane be divided into 4 groups based on their business: 2 belong to the public sector, 13 belong to the third sector, 4 are private and 2 are religious. As far as the organization is concerned: 3 are hospices, 2 are community centres, while the rest are residential facilities (Residential Care Facilities and nursing homes). These facilities host around 5,500 vulnerable elderly and were hosting around 22% less than their full capacity when the interviews were being conducted. There were a number of deaths between March and April (due to influenza mainly caused by COVID-19, even though death rates during those months had been considerable in the

previous years as well) which justify this percentage. Furthermore, the facilities could not accept new residents due to the strict isolation policies and the fight against the virus.

The care facilities were in a difficult situation caused by:

- the necessity to intervene urgently,
- the ambiguous requests by the public sector,
- the isolation from the residents' families,
- the health risks the operators and the residents were facing.

The managers of these facilities and the respective sectors were forced to make decisions, reorganize their work and reinvent their daily routine under highly unstable and uncertain conditions.

The objective of our study was to determine and analyze the processes able to:

- allow the facilities to continue to offer their services,
- elaborate new organization models;
- develop innovation and future strategies that would allow them to modify their elderly nursing care models.

Given the objective of the study and its exploratory nature, we chose the semi-structured interview as our instrument to conduct the same. All interviews were carried out through video calls (we used various platforms: Skype, MS Teams, Zoom) between the beginning of June and the first week of August 2020.

We were able to get in touch with the all facility managers (in some cases the managers were also medical figures who were also medical directors).

The average duration of each interview was two hours. All interviews were recorded and their contents transcribed in their entirety3. All data regarding the interviewees was kept anonymous while we highlighted data regarding the region, type of facility and its dimensions. The transcription was a key element in our contents analysis as it allowed us to highlight the organizational mechanisms that allowed the facilities to face the healthcare emergency period, from the first case in Italy to the end of the first lock-down.

The interview was structured in three parts:

1) beginning of the pandemic;
2) spreading of the virus and lock-down;
3) reopening after the lock-down and subsequent service revision.

Below we share the analysis of these three phases. In each phase we will analyze:

- the way the actors, especially the service managers and the operators, revised their facilities (and the relationship with their members), facing

[3] It is possible to have the integral transcriptions used for the analysis.

the challenged of an unpredictable, precarious, uncertain, risky and contradictory context;
- issues and opportunities regarding the institutions (local, regional and national);
- which networks and relationships they managed to maintain or create in order to have the necessary support and inspiration to face the challenges;
- what they consider necessary in order to revise their models in the future.

4. Data analysis

4.1 Phase 1- The beginning of the emergency and the unpopular choices

On 31st January 2020, the Italian government declared a 6-month national state of emergency. The decree was issued following the news arriving from China in the weeks prior to the state of emergency. However, local institutions as well as welfare services for the vulnerable citizens were not involved.

News regarding the COVID-19 pandemic reached the nursing homes in a very informal way, through the media, on 21st February 2020.

The nursing home managers received the news like any other citizen did and, given the silence of the local and national institutions, they independently had to look for information that would allow them to make quick decisions to protect their elderly residents and their staff.

Most of the facilities we interviewed closed their doors to visitors the following day, 22nd February 2020. This decision seemed quite drastic and it became very unpopular with the community as there had not been any indications in that direction on a local or national level. The families of the elderly residents started complaining and protesting almost immediately as their request for regular daily visits had been denied. At that point, no one knew how dangerous the virus really is, how easily it can spread nor the risks for a residential care facility for the vulnerable elderly.

Initially that decision seemed exaggerated. Some family members filed reports with the police, demanding an immediate reopening of nursing homes. After being pressured for a week by the families and the local community, and without any indications from the local and regional healthcare institutions, one medium-sized facility in Northern Italy decided to reopen to visitors. They adopted new safety and hygiene standards: only a limited number of visitors was allowed on the premises, their temperature had to be taken at the entrance and they had to wear gloves and use a hand sanitizer.

Subsequently, the managers had to justify their decision to reopen the facility as in March there had had a high number of deaths; apparently, the doors had been opened not only to the families but to the virus too.

The first phase was characterized by the emergency. In that phase, single actors, such as the health management, played the main role. They created dedicated crisis units and managed the facilities while collecting data on the characteristics and manifestations of the virus. The management modified their pandemic plan based on the situation at hand while trying to implement the most suitable care and protection practices.

In 2005, the spreading of the A/H5N1 bird flu was greatly emphasized on an international level in comparison to the mortality of a pandemic. The cover story that appeared on TIME magazine on 17th October 2005 reported on the healthcare experts' concerns regarding the pandemic. The experts were concerned about the millions of victims the pandemic would have taken and the destruction of the world economy caused by a worldwide lockdown. That year the Ministry of health created the "National plan for preparedness and response to an influenza pandemic[4]" which defined objectives and activities to undertake to avoid the devastation of pandemic. 2009 was the year of the swine flu, 2012 of the MERS and yet in 2020 the nursing homes did not possess updated pandemic plans and most of them did not have adequate personal protective equipment (henceforth PPE) supplies.

In a phase of emergency and uncertainty, the lack of clear indications from the local healthcare institutions and from the government posed a real problem for the facility managers who were forced to evaluate the emergency and make decisions on their own. However, the staff availability and competence (nurses, health and social service operators, educators, therapists etc.), their willingness to work long hours and their flexibility to cover various roles became a resource amidst uncertainty. They helped the crisis units identify the right lines of action and find what little information was available.

These work groups quickly realized that the most typical aspect of their daily activities (taking care of people who live inside a nursing home) became the element the wider community blamed the spreading of this highly contagious virus on.

Would it be possible to maintain physical distance between the residents or isolate them, if necessary, when many of them suffer from different pathologies, among which dementia?

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[4] National plan for preparedness and response to an influenza pandemic NCDPC-National Centre for Disease Prevention and Control). Ministry of health 2008.https://www.saluteinternazionale.info/wpcontent/uploads/2020/04/pianopandemico.pdf

The initial challenge seemed impossible. During the interviews, the representatives compared themselves to "astronauts on the moon": all of a sudden, the existing processes and the consolidated formal routines seemed inefficient. The lack of knowledge regarding pandemic protocols created further challenges: new sustainable daily practices had to be identified and new communication interfaces had to be created and implemented in order to reconnect the management and the staff; the staff and the residents; the management- staff-residents and the families.

4.2 Phase 2- Experiencing the emergency

The second phase coincides with the (first) lockdown from 9th March to 18th May 2020. When we conducted the interviews, that phases seemed to be the longest and the most complex one[5] .

During the second phase the facilities closed their doors to visitors once again (initially until a date to be decided later) and the residents were definitively separated from their families. It was as if the publication of the 8th March 2020 decree, signed by Giuseppe Conte who was the Prime Minister at the time, had built a wall between the nursing homes and the external world. Many could see that wall even though it was invisible. Most importantly, it was seen by the local and national public institutions that had not examined the nursing homes conditions and necessities for a long time.

At the end of March, the wall was partially torn down by the families' pleas caused by the growing number of deaths among the residents.

On the other side of that wall, inside the facilities, the crisis units were multiplying their efforts to obtain information and instruments to handle the emergency. The key word was: autonomy. The main problems at that point were:

- getting PPE supplies;
- finding information and trying to understand the fragmented indications given by the government and by the local health institutions;
- finding reliable sources of information in order to train the staff in terms of contagion prevention and activate transversal skills;
- finding new communication tools to use with the staff and with the residents' families;

[5] The researchers contacted the facility managers again during the winter to collect the results. The managers affirmed that the period between October and February(when the first vaccines arrived) was even more complex as they had to face the emergency with fewer supplies, understaffed and in an unaltered institutional context.

- managing the communication with the local institutions (especially after the "Nursing Home scandal" when they were defined as places of death);
- creating and implementing new tools and processes that would render the treatments sustainable during the pandemic.

In this analysis, we will focus on the processes that were activated during that period, especially those concerning the communication between the management, the operators, the residents, the families and the local community, as well as the relationship between the nursing homes and the public institutions.

Focusing on these aspects will allow us to shed light on what happened inside the nursing homes and to analyze the processes that were activated and that in return generated new types of governance and new services.

The first element that emerged from the interviews was the fact that the line between the managerial and the operative level had become blurrier (Bordieu 2015). The reason for that was the necessity to find new solutions using all the skills and knowledge possessed by both the managers and the operators, who accepted this state of continuous transformation of their know-how and redefinition of their roles. In most cases, the operators were completely available and their attitude allowed the facilities to regroup. In only a few cases operators were afraid of being infected and preferred protecting themselves.

One of the first problems was the management of staff training activities: the facilities had to act quickly, guarantee service continuity while making sure the staff respect the distancing rules. As far as the internal dynamics are concerned, the training activities focused on reviewing the communication practices in order to find new ways, means and time to communicate. The use of digital means solved the problem. For that purpose some facilities gave their staff devices such as cellphones or tablets, some introduced work platforms while others imbedded information programs into their work presence systems that informed everyone of new regulations, shifts changes etc.

As a part of their training activities, the facilities also reviewed their daily practices; for example, "clean and dirty" lanes were created and the patients and operators were located on different floors. According to the interviewees, that turned these comfortable and welcoming facilities into hospital wards. That aspect of the facilities intensified when the first residents started getting sick mid-March. The residents with COVID-19 -like symptoms were isolated even though they could not be tested as the first COVID-19 tests became available in April. The hospitals would not admit them due to their age and existing pathologies. Some isolated floors hosted the so-called "bubbles" of patients

with COVID-19 -like symptoms who were taken care of by staff members who accepted to perform that task.

Concerning the wall, its visibility or lack thereof depends on the contingent necessities of the local healthcare facilities. In a couple of cases, these facilities offered their space to hospitals in order to create COVID-19 wards. While the hospitals said no to admitting elderly patients coming from nursing homes, the local healthcare institutions said no to PPE availability. In fact, the Civil Protection officers were confiscating PPEs coming through customs and sending them to the hospitals. In some cases, the public opinion contributed to the growing tension between the nursing homes and the families through the local newspapers.

Finally yet importantly, the hospitals initiated a strong hiring campaign concerning highly qualified nursing staff thus depriving nursing homes of their best resources. These processes impoverished the nursing homes and their management was forced to thoroughly modify a number of internal organization processes. Even today these facilities lack staff and are working on improving their

Concerning the choice of PPE, training consultants and technologic devices, the contacts the nursing homes had with local institutions and Third Sector institutions proved crucial.

The long-term relationships based on collaboration, trust and solidarity became the most important capital nursing homes possessed in order to face the emergency and show that the local institutions "were there for them" even if a little disintegrated and lacking the institutional dimension (cited).

The digital environment became a way to keep alive the relationship with the families, regardless of the physical distance. The residents could make video-calls, videos and phone their families throughout the week, within the limits of their physical conditions. The managers were available in terms of providing the families with updates and information regarding their relatives/parents. In some cases, the nursing homes published their own magazines, written and edited by the operators and the residents, as a way to communicate with the families while in others, they prepared reports on the resident's conditions, which were e-mailed to the families or sent through the post office. These new communication tools gave nursing homes the possibility to activate projects for some of the residents connected to the use of the digital technologies and social networks. These tools gave them the possibility to communicate with their children and grandchildren and receive information for the world outside.

Finding new ways to communicate was rather quick and the devices were affordable. However, organizing the appointments was more complicated as it required having staff dedicated to managing the agenda and the emotional

aspects that emerged from the encounters between the residents and their families.

These new "kinds of relationships" between the residents and the families managed to loosen the tension and lower the discontent caused by the decision to close to visitors due to the pandemic. The managers noticed that, on the one hand, the families play a central role when it comes to the residents' wellbeing in terms of daily activities such as sharing a meal or spending time together. On the other hand, they noticed that in some specific moments of the day, the residents prefer slower-paced activities. This experience highlighted the necessity to solidify the trust between the management and the families as the element of trust had not been considered prior to the pandemic when the residents and their families could see each other on a daily basis.

Whenever possible, the management contacted the families to inform them of the declining health condition of their relatives/parents and gave the families the opportunity to visit their loved ones one last time to say their goodbyes. Not one resident was left to die alone (from the management to the staff, everyone was there to support the dying patients), no coffin was closed without the family being present. Each facility found ways and means to render their residents and families a priority, guaranteeing what by the contemporary collective imagination is considered as a 'good death' (Colombo 2021). The analysis of the interviews showed that the practices adopted by the nursing homes regarding the last goodbyes were the ones that made it possible to break down the wall between the inside and the outside. They re-established a strong link between the private experience of the families, on one side, and the collective experience of closure and confinement, and the subsequent pain caused by the impossibility to say goodbye to one's own family, friends and companions, on the other.

The choices made by the structures were guided by the desire to provide people with high-quality care during all phases of their lives, up to the moment they pass away. These choices made it possible, in this unique moment in history, to re-establish the value of customs. The people connected to these customs were able to find a new direction on a path they were familiar with and, at the same time, to put their trust in the people who have made that possible for them.

In summary, a series of problems that highlighted the existing criticalities emerged during the lockdown. Those problems overwhelmed the management that was already facing a complex situation caused by the emergency

The relationship with local and national public institutions was the biggest management burden. The nursing homes found it difficult, and at times even impossible, to communicate with the institutions. From their point of view, the difficulty to communicate was due to a number of reasons. First, the

government's disregard for the establishment of a Work Group created within the National Association of Health and Social Service Managers. Second, the absence of a Nursing Home manager in the emergency management task force appointed by the Prime Minister's Office. Third, the local health authorities did not facilitate the processes. They became controllers, applying sanctions, continually requesting data and performing inspections, while diverting all the PPE to their own hospital facilities and carrying out a massive campaign of hiring nursing staff.

4.3 Phase 3- Return to ordinary(new) life

The third phase concerns the period between 19th May and 1st July[6]. On a global level, that phase was known as "phase2" and it was thought to be the recovery phase following the emergency.

During that period, all nursing homes we interviewed were regularly performing swab tests on residents with specific symptoms as well as on staff and family members in order to monitor the situation. Thanks to those measures, the nursing homes were able to go back to a less-controlled, not emergency-oriented organization. Some old routines, such as meal menus, desserts and group moments were reintroduced and some facilities even reopened to visitors.

Less than one-half of the nursing homes had reintroduced family visits at the time of the interviews. The visitation protocols were very strict: the encounters were organized outside, there were physical barriers between the family member and the nursing home resident, only one person was allowed in and their temperature was measured at the entrance, they had to wear a face mask, sanitize their hands and wear gloves and booties. The encounters lasted between 15-20 minutes and an operator was present at all times to ensure that all protocols were followed. Some nursing homes decided not to reopen to family visits until they received the Regional Guidelines.

If on the one hand, the partial reopening was a sign of normality, on the other, it put a lot of pressure on the operators and the managers who had to manage the families in a very constraining and risky context. Both the management of the video calls and the "protected" encounters required a lot of effort in terms of dedicated staff, which prior to the pandemic were not considered complex activities in terms of organization. On the contrary, they were seen as a resource when it came to the management of some daily activities (feeding the elderly, keeping them company, etc.)

[6] 19th May marks the end of the lockdown; starting from 3rd June the travel between the regions became once again possible. The research was completed at the end of July but that period has no significance in terms of "pandemic management calendar".

The reopening was a much-awaited event, not only by the families anxious to see their parents and relatives but also by the nursing homes regarding the new admissions that had been put on hold since the beginning of the lockdown.

Being able to accept new residents became crucial for their survival as nursing homes had had economic problems due to the loss of around 20% of their residents and the acquisition of PPE supplies, other equipment and new staff.

Some nursing homes created their own guidelines regarding the new admissions and presented them to the Regional institutions that have hesitated giving clear indications regarding the topic. During phase 3, many facilities finally had the possibility to elaborate the experiences they had had in the previous months, keeping in mind the future of their mission and their internal organization.

In that sense, given the high emotional charge, many nursing homes decided to reinvent themselves and introduce psychological counseling in order to offer support to the entire staff and lessen their emotional burden, as well as to review their activities and processes. The necessity to re-interpret those experiences was confirmed by the fact that, most the interviewees thanked the researchers at the end of the interviews for having given them the possibility to replay and reorganize them. The thought process circuits activated by the research instruments helped the nursing homes review their internal organization.

Even though the nursing home reinvention process was in progress when we completed the interviews, the management were able to list the elements they deemed most important when it comes to caring for vulnerable elderly individuals.

We can list four areas that according to us outline the transformation standards that need to be adopted by the nursing homes I order to render them homes, therefore places where people are taken care of, rather than spaces isolated from their local communities (Fazzi 2014; Berloto et. al. 2020)

According to the interviewees, the fist aspect that needs to be transformed is the culture. Nursing homes need to adopt an approach that recognizes the right to care that places the elderly, their personal history, their needs and relationships in the center. That can be done by abandoning the current approach based on planning and adopt a new approach free of prejudice towards private institutions dedicated to elderly care. Nursing homes should seen as places where the elderly are taken care of not managed. Furthermore, we need to invest in staff training and the same should be based on experience and research.

The second area is the governance. Currently the healthcare and the welfare sector are two independent sectors that often have difficulties to create

synergies, even when that is necessary. The nursing homes experience regarding the most acute phase of the pandemic showed us that, on the one hand, there is no care service cohesion, but on the other, the regions are connected through the skills and competences possessed by members of associations and institutions of the third sector who operate on solidarity and mutual help. The welfare and healthcare governance need to be based on community care able to join together knowledge, expert and caregiver skills and competences and lean bureaucracy.

According to the interviewees, the elderly care transformation should include transformation of the facilities and the services they offer. Nursing homes are often located in old historical buildings that have been donated by families or to religious institutions. These buildings require a lot of architectural and structural maintenance. In some cases, the ventilation and sanitation systems have to be updated. In others, the common rooms and the canteen have to be redesigned. Furthermore, the new models have to consider what is best for the residents- single or double bedrooms.

Finally, concerning the tools and interventions to be introduced, the interviewees highlighted the need to improve the prevention of viral diseases in the elderly through integrated medicine, correct nutrition and reconsidering some hygiene practices.

They also believe that telemedicine as well as palliative treatments should be both adopted and made more available to different types of patients. Service innovations can only thrive if we invest in staff training and focus not only on specific knowledge but also on the soft skills that facilitate teamwork and interventions in times of emergency and uncertainty. Finally, the pandemic has drawn attention to the strong link between the various types of wellbeing (physical, psychological and relational dimensions), so they hypothesize that the nursing homes should offer psychological support, through a structured service, to both the residents as well as to the operators, guests, and families.

5. Conclusions

At the end of this study, which led us to thoroughly explore the events that took place in 22 nursing homes during the first pandemic phase, we would like to briefly highlight three aspects, focused on 3 key words, which we consider relevant in relation to the data that emerged from our study and to the ongoing debate regarding: the non-self-sufficiency reform, the territorialization of the health system and the innovative policies (NNA 2021).

The first key word is care, which, seen as a fundamental human experience - in a context of social investment - becomes the fundamental right underlying

the recognition of citizenship (Kittay, Jennings, Wasunna 2005; Nussbaum 2012). As early as the mid-1970s, Ivan Illich spoke about iatrogenesis in terms of care transformation - from an ethical and social matter to a technical and procedural one. In recent decades, management has seized control over welfare and social services and they have been specifically focusing on tasks, especially on their technical content and proceduralization in order to lower the uncertainty and personal responsibility of the operator (Illich 2013). Care is a daily practice, which requires engagement, personalized interventions and the work of many actors with different competences (community care) (The Care Collective 2021; Di Nicola, Viviani 2020). The medical humanities movement is advancing the idea that quality health care should combine technical skills with contemplative skills, necessary to acquire thorough understanding of the situation at hand (Mortari 2021). Caring requires that the caregivers, in addition to possessing technical competences, feel responsible for the wellbeing of the person they are taking care of (Macchioni, Maestri 2018).

The second key word we would like to highlight is territorial governance. Various groups have underlined the necessity to redefinition the health and social-welfare sectors, thus enhancing the territory. It is precisely the concept of territory that we believe needs to be reviewed in terms of mutual cooperation with multiple social, economic, political and cultural effects. The objective is to create a context capable to increase the common resources necessary for the work of all the actors involved (Magnaghi 2020).

This concept of territory implies the necessity of an experimental polyarchy governance capable to recognize the importance of the various local actors and the same are given freedom, by the central institutions, to pursue clear collective goals (Sabel 2013). The central institutions monitor and evaluate local performance; collect and compares information; create pressure and opportunities for continuous improvement at all levels. This is a winning governance model because it can easily adapt in contexts characterized by uncertainty that require radical innovation (Prandini, Orlandini 2018)

The third keyword is care manager. In the field of services, the new professions (service profession) are oriented towards developing competences and functional responses for risk areas, interacting and collaborating with the actors operating in educational, social and productive contexts.

The aim is therefore to enable users, collaborators and citizens to find their way around the plurality of services, languages and documents, in a context able to integrate the various organizational and cultural approaches of the services provided in a specific area.

These professionals can create shared social value through knowledge sharing, extensive communication, community building and the adoption of open organizational models (Tomelleri e Massagli, 2019).

The shared construction of meaning stems from the thought process that the Care Manager develops through the continuous interaction with the members of his network. Thanks to the Care Manager's role, the territory becomes a functional space made up of a variety of actors who establish boundaries of meaning, take care of it as a place of growth and development.

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