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REVIEW ARTICLE

Facilitators and barriers to autonomy: a systematic literature review for older adults with physical impairments, living in residential care facilities

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Abstract

Autonomy is important in every stage of life. However, little is known about how autonomy is enhanced for older adults living in residential care facilities (RCFs). This leads to the research question: which facilitators and barriers to autonomy of older adults with physical impairments due to ageing and chronic health conditions living in RCFs are known? The results will be organised according to the framework of person-centred practice, because this is related to autonomy enhancement. To answer the research question, a systematic literature search and review was performed in the electronic databases CINAHL, PsycINFO, PubMed, Social Services Abstracts and Sociological Abstracts. Inclusion and exclusion criteria were derived from the research question. Selected articles were analysed and assessed on quality using the Mixed Methods Appraisal Tool. Facilitators and barriers for autonomy were found and arranged in four themes: characteristics of residents, prerequisites of professional care-givers, care processes between resident and care-giver, and environment of care. The established facilitators and barriers are relational and dynamic. For a better understanding of the facilitators and barriers to autonomy for older adults with physical impairments living in RCFs, a description is based on the 35 included articles. Autonomy is a capacity to influence the environment and make decisions irrespective of having executive autonomy, to live the kind of life someone desires to live in the face of diminishing social, physical and/or cognitive resources and dependency, and it develops in relationships. The results provide an actual overview and lead to a better understanding of barriers and facilitators for the autonomy of older adults with physical impairments in RCFs. For both residents and care-givers, results offer possibilities to sustain and reinforce autonomy. Scientifically, the study creates new knowledge on factors that influence autonomy, which can be used to enhance autonomy.

Keywords: autonomy; residents; physically impaired; residential care facilities; older adults; person-centred practice; nursing home; systematic review

Introduction

In many Western countries, governments see active citizenship as an important theme. A neoliberal philosophy has influenced and changed health-care systems during the last decade. Now, citizens should take personal responsibility and participate in society as independent individuals. This responsibility also concerns health and welfare (Verhoeven and Tonkens, 2013). The worldwide trend in health care is that older adults with chronic conditions and physical impairments continue to live at home (Cartier, 2003; Bjornsdottir, 2009; Jacobs, 2019). Policies are directed towards self-management and informal care from family and friends.

If living at home is no longer possible – *e.g.* due to severe physical impairments – admission to a residential care facility (RCF) is permitted. How is participation achieved in a facility that is a place to live as an individual, as well as a place where the resident is dependent on others to receive appropriate care? The authors focus on older adults with psychological impairments due to age-related decline and chronic health conditions (further to be called: residents with physical impairments). Generally speaking, these persons are able to make decisions on how they want to live their lives, but are often not able to execute the decisions they make themselves. The focus of this review article is to gain insight into which facilitators and barriers influence autonomy of older adults with physical impairments.

Living in residential care influences autonomy. The authors are investigating this influence because they have the presumption that intervening on these facilitators and barriers for this specific group will create better opportunities for their autonomy.

The concept of participation is discussed in the light of diverse psychological and sociological research and is described with words such as ‘control’, ‘agency’, ‘mastery’, ‘autonomy’, ‘self-management’ and ‘self-determination’ (Morgan and Brazda, 2013). The authors of the current review chose to use the word autonomy because of the decisional *versus* executional polarity. This polarity was described by Collopy (1988) as follows: a resident can have a desire and make decisions on how she/he wants to live her/his life, even if she/he cannot actualise them.

Moreover, in RCFs, several residents with physical impairments live together and can simultaneously have incompatible needs and wishes (Bolmsjö *et al.*, 2006). Autonomy is given shape in a relational context between staff and other residents (Abma *et al.*, 2012; Baur and Abma, 2012; Gleibs *et al.*, 2014; Oosterveld-Vlug *et al.*, 2014). McCormack (2001) challenges the ‘individualistic concept of autonomy’ as used in neoliberal tradition and gives a different view based on interconnectedness and person-centred care.

The aforementioned relationship between autonomy and person-centred care can help to study autonomy in more detail. The aim of person-centred care is to place residents at the centre: in other words, each resident is seen as a unique person with a personal history, future and life goals. With person-centred care, caregivers can respect and enhance autonomy of residents in the last phase of their lives (Danahauer *et al.*, 2006; Donnelly and MacEntee, 2016). McCormack and McCance (2017) formulated a leading theory of person-centred practice (PCP) which can

help to reflect upon facilitators and barriers to autonomy. It offers a theoretical, evidence-based framework. PCP is seen as a multi-dimensional concept and it is still developing. It takes into account person-centred outcomes (e.g. involvement in care), person-centred processes (e.g. sharing decision-making), the care environment (e.g. appropriate skills mix in the nursing team), prerequisites of staff (e.g. providing holistic care) and the macro context (e.g. health and social care policy) (McCormack and McCance, 2017).

A better understanding of the factors that strengthen autonomy (facilitators) or undermine autonomy (barriers) can help to enhance practices in RCFs that lead to interventions to preserve and facilitate autonomy of older adults with physical impairments living in RCFs. For a better understanding, the authors will underpin the concept of autonomy for older adults living in RCFs with a description that will be derived from the literature.

A systematic literature review will be executed with the research question: which facilitators and barriers to autonomy of older adults with physical impairments due to ageing and chronic health conditions living in RCFs are known?

Method

To answer the research question, a systematic literature search was conducted in the following databases: PubMed, CINAHL, Social Services Abstracts, Sociological Abstracts and PsycINFO. These databases include articles about care, cure and psycho-social functioning. For the central aspects, living in an institution for long-term care and autonomy, the thesaurus (Social Services Abstracts, Sociological Abstracts and PsycINFO), MESH terms (PubMed) and headings (CINAHL) were used to select search terms that best matched the research question (Table 1). The search was conducted in March 2016 and updated in July 2017. A limit of ten years (beginning from 2006) was chosen, because the neoliberal approach of participation and the role of autonomy has only been put into laws and regulations over the last decade. The question of how autonomy can be enhanced for the more vulnerable members of society also emerged in this period.

Inclusion and exclusion criteria were established to be sure to review articles that concern the residents under study, namely older adults with physical impairments due to ageing and chronic conditions who live in RCFs (Table 2).

Selection

Figure 1 shows the results of the database search. Using the inclusion and exclusion criteria (Table 2), the titles of the 3,030 unique articles were screened by the first author (JvL). When in doubt, the article went to the next stage. Selection by abstract was performed independently by JvL and three co-authors (KL, IdR and BJ). These co-authors each reviewed one-third of the articles and JvL reviewed all the articles. Afterwards, the selections were discussed in pairs of reviewers in order to reach a consensus. When no consensus was reached on an article, it was included in the next stage. The same procedure was followed for the full-text selection. When no consensus about inclusion or exclusion was reached in this stage, a third author was consulted and a consensus was reached.

Table 1. Search terms and strategy

Autonomy:
<ol style="list-style-type: none"> 1. Actualisation OR 2. Self-actualisation OR 3. Self-determination OR 4. Self-management OR 5. Self-efficacy OR 6. Client participation OR 7. Patient participation OR 8. Autonomy OR 9. Personal autonomy OR 10. Coping OR 11. Resilience OR 12. Self-care OR 13. Patient autonomy OR 14. Adaptation OR 15. Hardiness
AND
Care setting:
<ol style="list-style-type: none"> 1. Residential facilities OR 2. Long-term care OR 3. Residential care OR 4. Nursing home patients OR 5. Homes for the aged

Table 2. Inclusion and exclusion criteria for autonomy and its facilitators and barriers

Inclusion:
<ol style="list-style-type: none"> 1. Older adults living in residential care facilities with physical impairments. 2. Time period March 2006 to July 2017. 3. Written in the English language. 4. Empirical research. 5. Peer-reviewed journal article. 6. Health technology as far as it concerns the autonomy of residents. 7. Care-givers/family care as far as it concerns the autonomy of residents. 8. Professional care-giver issues as far as it concerns the autonomy of residents. 9. The decision to move, or process of moving, to long-term care.
Exclusion:
<ol style="list-style-type: none"> 1. Persons suffering from dementia, psychiatric disorders and mentally challenged persons. 2. Place of living: in community, hospital and rest home. 3. Average age younger than 65 years. 4. Specific diseases and impairments. 5. Specific treatments of diseases. 6. Self-management of diseases like diabetes and blood pressure control.

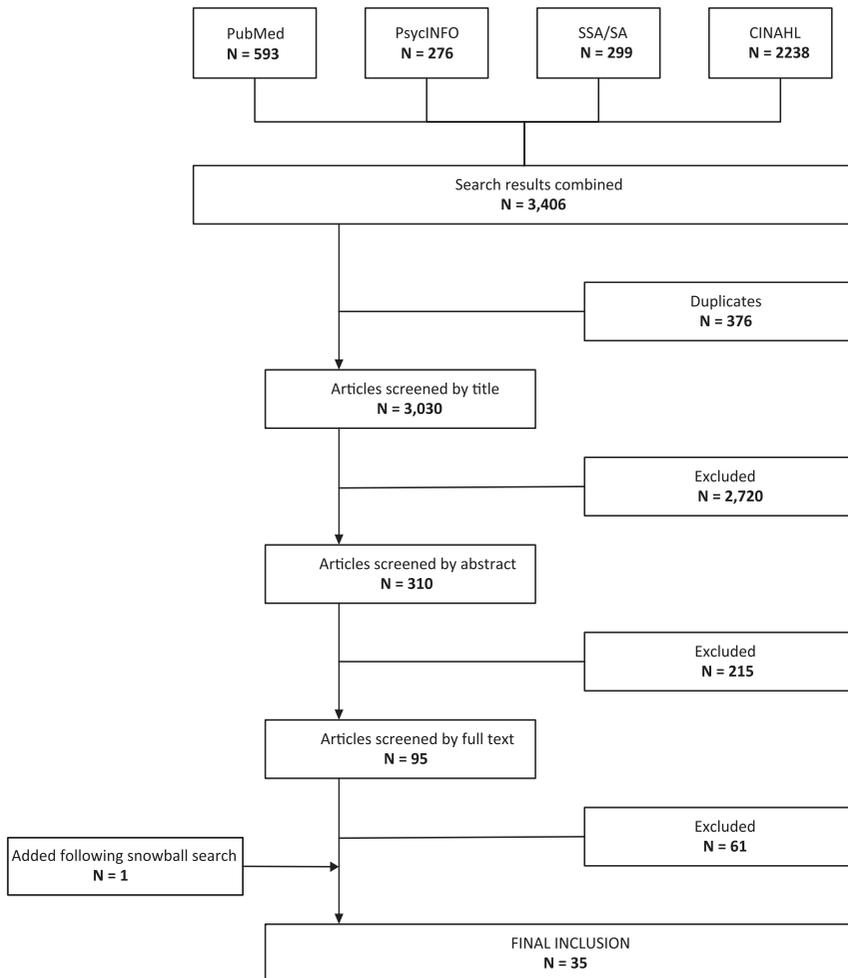


Figure 1. Flowchart of the database search of facilitators and barriers to autonomy.

Note: SSA/SA: Social Services Abstracts and Sociological Abstracts.

Data extraction and quality assessment of the articles

The data extraction of the full texts was performed using a format wherein the authors independently noted the description and the position of autonomy (*i.e.* cause, mediator or result). Apart from one article (Brandburg *et al.*, 2013), the descriptions were given in the Introduction section in which the authors clarify how they were going to use the concept in their study.

Subsequently, the authors noted facilitators and barriers as given in the Results sections of the articles. Afterwards JvL and KL, JvL and IdR, and JvL and BJ compared and discussed the extracted data in order to compare and interpret the data.

Each article was also assessed on quality, again independently by JvL and KL, IdR and BJ. The results of the assessed quality were also discussed in bilateral

sessions. Because the systematic review includes articles with qualitative, quantitative and mixed-methods designs, the Mixed Methods Appraisal Tool (MMAT) was used to assess the quality of the selected articles. The MMAT is developed to facilitate the concurrent appraisal of articles with different designs, and provides elements to assess the quality of the articles to be included (Pace *et al.*, 2012). In order to do so, four elements for studies with a qualitative or quantitative design are defined; for mixed-method designs, 11 elements are defined. The scores are reported in column 3 of Table 3.

Data synthesis

The facilitators and barriers (*see* Table 3, columns 7 and 8) were organised by JvL, KL, IdR and BJ in three themes derived from the PCP framework (McCormack and McCance, 2017). Because a large group of facilitators and barriers found in the included articles concerned the residents themselves, the authors decided to add the theme ‘characteristics of residents’. The current article thus uses four themes that affect autonomy, namely characteristics of residents, prerequisites of professional care-givers in RCFs, processes in the relationship between residents and professional care-givers, and the care environment. When the context of the facilitators and barriers in an included article was not clear enough to assign it to one theme, the authors chose to assign it to more than one.

The included studies did differ in method and quality. However, the authors decided not to exclude the six articles scoring below 75 per cent because they provided relevant information on the research question. Moreover, in the analyses and presentation of the results, articles with a low MMAT score will not dominate.

Elements from the descriptions (Table 3, column 6) were used to make a general description of autonomy for older adults with physical impairments in RCFs.

Reliability

The authors started with an individual review of ten abstracts using the inclusion and exclusion criteria. In a meeting, they discussed the similarities and differences in the selection. The same was done in the stage of the full-text selection, this time with two articles. In this way, a uniform selection procedure of abstracts and full texts was achieved. At each selection stage, the first author (JvL) reviewed all the articles and the co-authors (KL, IdR and BJ) each reviewed one-third of the articles. The articles were discussed bilaterally between JvL with KL, IdR and BJ. When no consensus was reached, the article was reviewed again in the next stage. At each stage, the articles switched to another reviewer. The stage of data extraction and quality assessment was also preceded by a meeting with all reviewers to discuss the analysis and assessment process.

Results

The search identified 3,030 unique articles, of which 35 were included. Table 3 (column 2) shows that most of the articles originate from North-West Europe, Australia and North America. The MMAT scores (column 3) vary from 25 to

Table 3. Description of the included articles and results

Authors and year	Country	MMAT quality score (%)	Title of the article	Design (D), number of participants (N), population (P), age (A) and mean age (M)	Description of autonomy (as described in the Introduction section)	Facilitators (as described in the Results section)	Barriers (as described in the Results section)
Abma <i>et al.</i> , 2012	NL	100	Responsibilities in elderly care: Mr Powell's narrative of duty and relations	D: Qualitative: observations N: 1 P: Resident A: 92 M: Not applicable	Autonomy is relational and 'entails self-worth and self-development' and is 'an interactive process requiring the help and support of others' (p. 28).	Helping to see limitations. Reciprocity and mutuality. Listening to life stories.	Not listening. Not helping to adapt expectations.
Anderberg and Berglund, 2010	Sweden	100	Elderly persons' experiences of striving to receive care on their own terms in nursing homes	D: Qualitative: interviews N: 15 P: Residents A: 73–98 M: 82.4	Maintaining the 'abilities in order to have a sense of control in their life' (p. 67).	Learning dimension: the ability to find your way in the NH.	
Andresen <i>et al.</i> , 2009	Denmark	50	Perceived autonomy and activity choices among physically disabled older people in nursing home settings: a randomized trial	D: Quantitative: questionnaires N: 50 P: Residents A: 65–97 M: –	Perceived autonomy in choice and control over activities in daily life.	Individually tailored programmes for activities.	Schedules for activities such as rest.
Baur and Abma, 2012	NL	100	'The Taste Buddies': participation and empowerment in a residential home for older people	D: Qualitative: action research N: 7 P: Residents A: 82–92 M: –	Empowerment through collective participation.	Relational process as a catalyst for change. Supporting environment; role models facilitate empowerment.	

(Continued)

Table 3. (Continued.)

Authors and year	Country	MMAT quality score (%)	Title of the article	Design (D), number of participants (N), population (P), age (A) and mean age (M)	Description of autonomy (as described in the Introduction section)	Facilitators (as described in the Results section)	Barriers (as described in the Results section)
Bolmsjö et al., 2006	Sweden	100	Everyday ethics in the care of elderly people	D: Qualitative: observations N1: 12 observed P1: Residents A: – M: – N2: – P2: Staff of P1 A: 20–60 years M: –	Autonomy is ‘having the possibility to decide, influence and have choice in ... daily life (self-determination) and also by not being dependent’ (p. 253).	Ethical competence of staff leads to autonomy.	Ethical incompetence leads to less autonomy and wellbeing.
Brandburg et al., 2013	USA	100	Resident strategies for making a life in a nursing home: a qualitative study	D: Qualitative: interviews N: 21 P: Residents A: 65–93 M: –	Resilience: ‘ability to adapt successfully to challenges in life’ (p. 866). ¹	Personal resilience and strategies for coping and adapting (after a move).	Unplanned move to NH interferes with successful adaptation.
Chao et al., 2008	Taiwan	50	Predictors of psychosocial adaptation among elderly residents in long-term care settings	D: Quantitative: questionnaires P: Residents N: 126 A: 65–102 M: 81	Psycho-social adaptation: ‘the ability of elders to maintain a sense of self-identity and continue valued roles and interactions with others while adapting to life in a long-term care facility’ (p. 150).	Voluntary admission. Having roommates. Higher functional status. Financial resources. Having family support.	Absence of family support.

Cooney <i>et al.</i> , 2009	Ireland	100	Resident perspectives of the determinants of quality of life in residential care in Ireland	D: Qualitative: interviews N: 101 P: Residents A: 65–90+ M: –	Quality of life: ‘sense of wellbeing, perceived happiness and life satisfaction ... independence, social activity and perceived control over life’ (p. 1030).	Maximising potential: ethos of care, sense of self and identity, connectedness, activities and therapies. Physical environment: homely atmosphere. Social environment: good relationships with continuity and reciprocity.	Physical environment: absence of homely social spaces; poor toilet and bathroom provisions. Social environment: staff are seen as too busy; negative social relations; no potential to stay connected.
Curtiss <i>et al.</i> , 2007	USA	25	Motivation style, lengths of residence, voluntariness, and gender influences on adjustment to long-term care: a pilot study	D: Quantitative: questionnaires N: 75 P: Residents A: 69.5–88.8 M: –	Self-determination style that is related to adaptation.	Self-determined coping style helps to cope with institutional life.	
Custers <i>et al.</i> , 2010	NL	75	Need fulfillment in caring relationships: its relation with well-being of residents in somatic nursing homes	D: Quantitative: questionnaires N: 88 P: Residents A: 50–97 M: 78.5	Autonomy: ‘one can choose activities, make decisions and regulate behaviour in accordance with own goals’ (p. 732).	High-quality care relationships contribute to need fulfillment, less depressive feelings and more life satisfaction.	
Custers <i>et al.</i> , 2011	NL	100	Need support and wellbeing during morning care activities: an observational study on resident–staff interaction in nursing homes	D: Quantitative: observation and questionnaires N: 20 P: Residents A: 54–93 M: 79.1	Autonomy: ‘one can choose activities, make decisions and regulate behaviour in accordance with own goals’ (p. 1428).	Care-givers that fulfil the need for autonomy, relatedness and competence.	

(Continued)

Table 3. (Continued.)

Authors and year	Country	MMAT quality score (%)	Title of the article	Design (D), number of participants (N), population (P), age (A) and mean age (M)	Description of autonomy (as described in the Introduction section)	Facilitators (as described in the Results section)	Barriers (as described in the Results section)
Custers <i>et al.</i> , 2012	NL	25	Relatedness, autonomy, and competence in the caring relationship: the perspective of nursing home residents	D: Mixed methods: questionnaires and interviews N: 35 P: Residents A: 55–93 M: 79.9	Autonomy: ‘one can choose activities, make decisions and regulate behaviour in accordance with one’s goals’ (p. 320).	Higher ADL dependency. Match between individual preferences and support. Asking for preferences. Facilitating care-givers to act upon the preferences. Higher education of staff.	
Danhauer <i>et al.</i> , 2006	USA	75	Accenting the positive recent ‘uplifts’ reported by nursing home residents	D: Mixed methods: questionnaires N: 93 P: Residents A: 65–104 M: 83.46	‘domains of quality of life to accentuate the positive ... [including] autonomy’ (p. 40).	Experiencing moments of good life: uplifts.	
Donnelly and MacEntee, 2016	Canada	100	Care perceptions among residents of LTC facilities purporting to offer person-centred care	D: Qualitative: interviews N: 23 P: Residents A: 58–97 M: 83.43	‘Person-centred care ... enhance ... autonomy’ (p. 150).	Outspoken residents maintain some sense of autonomy.	Staff impose activities or care.

Dunworth and Kirwan, 2012	USA	100	Do nurses and social workers have different values? An exploratory study of the care for older people	D: Mixed methods: questionnaires N: 65 P: Staff of residential care facilities A: 40 ≥ 40 years M: –	No description.	Care-qualified staff have fewer ageist assumptions.	Non-care-qualified staff give priority to safety as opposed to autonomy.
Gleibs <i>et al.</i> , 2014	UK	75	‘We get to decide’: the role of collective engagement in counteracting feelings of confinement and lack of autonomy in residential care	D: Qualitative: interviews N: 10 P: Residents A: 76–99 M: –	‘Confinement ... as it related to ... control or autonomy’ (p. 268).	Empowerment: enable voice, choice, control and belonging through group activities. Helping others. Social relations.	Ageism and stereotypes. Physical environment: needing help going outdoors and to other spaces. Lack of control. Physical mobility.
Hall <i>et al.</i> , 2014	UK	75	Maintaining dignity for residents of care homes: a qualitative study of the views of care home staff, community nurses, residents and their families	D: Qualitative: interviews N: 121 Subsets P1: Staff; P2: Family; P3: Residents (15) A: 56–93 (P3) Median: 80.5	‘Independence, autonomy, choice and control are related concepts concerning self-determination (not being restrained, influenced or coerced by others) and not relying on others for aid or support’ (p. 57).	Maintain dignity through: independence, autonomy, choice, privacy, control. Values of staff. Communication skills of staff.	Lack of privacy. Persuasion. Prioritising physical care and safety above autonomy. Workload of staff.

(Continued)

Table 3. (Continued.)

Authors and year	Country	MMAT quality score (%)	Title of the article	Design (D), number of participants (N), population (P), age (A) and mean age (M)	Description of autonomy (as described in the Introduction section)	Facilitators (as described in the Results section)	Barriers (as described in the Results section)
Hellström and Sarvimäki, 2007	Sweden	50	Experiences of self-determination by older persons living in sheltered housing	D: Qualitative: interviews N: 11 P: Residents A: 73–93 M: –	‘[A]utonomy was conceived as self-determination’ (p. 413). ‘Self-determination ... is connected ... to activity, mental agility, survival, social wellbeing, self-image and health’ (p. 414).		Disempowerment by the environment, <i>e.g.</i> lack of information and shortage of staff, does not strengthen individual self-determination, participation and control. Feeling worthless. Being immobile.
Hillcoat-Nallétamby, 2014	UK	75	The meaning of ‘independence’ for older people in different residential settings	D: Qualitative: interviews N: 91 P: Residents Subset NH: N: 29 A: 74.5–89.5 M: 82	Autonomy has the dimensions: delegated, decisional, authentic, executional, consumer and direct autonomy.	Accepting help at hand. Doing things alone. Having friends, family and financial resources. Preserving physical and mental capacities.	
Hwang <i>et al.</i> , 2006	Taiwan	100	Correlates of perceived autonomy among elders in a senior citizen home: a cross-sectional survey	D: Quantitative: questionnaires and interviews N: 121 P: Residents A: 65–92 M: 78	‘Autonomy ... is being able to recognize one’s own individuality, having the freedom of self-determination, and ... the freedom to act’ (p. 431).	Satisfaction of social support. Functional ability. Life attitudes. Literacy.	

Johnson and Bibbo, 2014	USA	75	Relocation decisions and constructing the meaning of home: a phenomenological study of the transition into a nursing home	D: Qualitative: questionnaires and interviews N: 18 P: Residents A: 68–97 M: –	‘[A]utonomy ... the experience of having freedom and/or choice in daily living’ (p. 61).	Self-adjustment: coping with the situation. Looking for some autonomy within the institutional limitations. Making the decision to move. A safer place than the previous housing. Room for possessions.	Not participating in the choice to move. Giving up control. Lack of choice. Restrictions on going outside.
Knight <i>et al.</i> , 2010	UK	100	In home or at home? How collective decision making in a new care facility enhances social interactions and wellbeing among older adults	D: Quantitative: questionnaires and observations N: 27 P: Residents A: 67–92 M: –	Collective decision-making, engagement and ownership.	Enhanced by participating in group decision-making in the context of the living environment.	
Knight <i>et al.</i> , 2011	Australia	100	Environmental mastery and depression in older adults in residential care	D: Quantitative: questionnaires N: 96 P: Residents A: 64–98 M: 83.5	Environmental mastery ‘managing one’s environment, an ability to control external activities and to select or develop contexts suitable to one’s needs’ (p. 875).	Mastery leads to better mental health in cases of illness and functional impairment.	

(Continued)

Table 3. (Continued.)

Authors and year	Country	MMAT quality score (%)	Title of the article	Design (D), number of participants (N), population (P), age (A) and mean age (M)	Description of autonomy (as described in the Introduction section)	Facilitators (as described in the Results section)	Barriers (as described in the Results section)
Lagacé <i>et al.</i> , 2012	Canada	50	The silent impact of ageist communication in long term care facilities: elders' perspectives on quality of life and coping strategies	D: Qualitative: interviews N: 33 P: Residents A: 60–100 M: –	'Communication is an essential component of the caring relationship, ... maintain strong and empowering social bonds' (p. 335).		Ageist communication leads to feelings of being patronised and controlled: it discourages autonomy. Elders react with avoidance strategies (thus reinforcing ageist communication).
Lee <i>et al.</i> , 2013	UK	75	A narrative exploration of older people's transitions into residential care	D: Quantitative: interviews N: 8 P: Residents A: 65–97 M: –	Mastery over environment.	More control and involvement in the environment.	Withdrawal, giving up.
Morgan and Brazda, 2013	USA	75	Transferring control to others: process and meaning of older adults in assisted living	D: Qualitative: interviews N: 77 P: Residents A: 59–99 M: 85	Sense of personal control in the face of diminishing physical, cognitive or social resources.	Transfer of control to others is seen as proactive and positive to attain goals.	Over-helping, incongruent support and taking over control.

Nåden <i>et al.</i> , 2013	Norway, Sweden, Denmark	100	Aspects of indignity in nursing home residences as experienced by family caregivers	D: Qualitative: interviews N: 28 P: Family care-givers of residents (also dementia) A: 47–89 M: –	‘dignity ... respect for personal autonomy’, ‘central elements in dignity are respect, privacy and control’ (p. 749).		Being abandoned and deprived of dignity due to: (a) feelings of not belonging; (b) acts of omission/offences; (c) deprivation of confirmations; (d) physical humiliations; (e) psychological humiliations; (f) aspects of institutional life: staff are not able to provide good care, ageist communication.
Oosterveld-Vlug <i>et al.</i> , 2013	NL	100	Changes in the personal dignity of nursing home residents: a longitudinal qualitative interview study	D: Qualitative: interviews N: 30 P: Residents A: 49–102 M: –	‘personal dignity, a type of dignity that is subjectively experienced by an individual’ (p. 1).	Coping mechanism and professional care helps to maintain or regain personal dignity by feeling in control of life. Being regarded as a worthwhile person by themselves and others.	
Oosterveld-Vlug <i>et al.</i> , 2014	NL	100	Dignity and the factors that influence it according to nursing home residents: a qualitative interview study	D: Qualitative: interviews N: 22 P: Residents A: 49–97 M: 77	‘Dignity ... personal, subjective valuing of oneself, ... valuing oneself by others’ (p. 98).	Preserving personal dignity through good professional care and a supportive social network.	Lack of privacy. Staff not knowing the resident. Leaving behind loved ones.

(Continued)

Table 3. (Continued.)

Authors and year	Country	MMAT quality score (%)	Title of the article	Design (D), number of participants (N), population (P), age (A) and mean age (M)	Description of autonomy (as described in the Introduction section)	Facilitators (as described in the Results section)	Barriers (as described in the Results section)
Palacios-Ceña <i>et al.</i> , 2013	Spain	100	Is the mealtime experience in nursing homes understood? A qualitative study	D: Qualitative: interviews N: 26 P: Residents A: ≥ 60 M: 83	No description.	Work with preferences on mealtimes: maximise autonomy, promote positive social experience, optimise dietary intake and improve quality of life.	Dining table allocation by staff and/or as reward or punishment.
Råholm <i>et al.</i> , 2014	Norway, Sweden, Denmark	100	Perspectives of dignity of residents living in nursing homes: experiences of family caregivers	D: Qualitative: interviews N: 28 P: Family care-givers of residents (also dementia) A: 47–89 M: –	'[I]n the concept of dignity: the concrete level, the relational level, and the existential level' (p. 37).	Providing a confirming culture and a caring and confirming relationship.	The existence of a non-confirming and non-caring relationship.

Sæteren <i>et al.</i> , 2016	Denmark, Sweden, Norway	100	The dialectical movement between deprivation and preservation of a person's life space	D: Qualitative: interviews N: 28 P: Residents A: 62–103 M: –	Dignity is experienced in 'maintaining personal life space in relation to the physical environment, confirming interpersonal relations, and a feeling of inner freedom and worth ... despite the onset of aging, disease and disability' (p. 139).	Using the inner resources residents have. Giving as much space as possible to protect the residents' responsibilities and inner freedom. Express needs and desires in a negative way: claim the right.	Being dependent in terms of mobility. Not complaining; accepting withdrawal.
Sikorska-Simmons, 2006	USA	75	The effects of organizational policies on resident perceptions of autonomy in assisted living	D: Quantitative: questionnaires N: 412 P: Residents A: 59–101 M: 83	Decisional autonomy: 'perceptions of influence and independence' (p. 62).	Higher levels of choice-enhancing policies.	
Walent and Kayser-Jones, 2008	USA	75	Having a voice and being heard: nursing home residents and in-house advocacy	D: Qualitative: interviews and document review N: 17 P: Residents A: 66–94 M: –	'Self-advocacy ... ability to voice one's own needs and concerns and to persist until they were heard and met' (p. 39).	Formal advocacy: the organisation promotes the residents' voice by pairing employees with residents. Residents who are advocates for other residents.	Personal, organisational, social and cultural barriers.
Walker and Paliadelis, 2016	Australia	100	Older peoples' experiences of living in a residential aged care facility in Australia	D: Qualitative: interviews N: 18 P: Residents A: 77–96 M: –	'losing control over making life choices' (p. e7).	Meaningful relations with staff, family and friends. Acceptance. Making the best.	Trading independency for safety and assistance in NH. Exclusion from formal decision-making.

Notes: 1. Given in the Results section. MMAT: Mixed Methods Appraisal Tool. NL: The Netherlands. USA: United States of America. NH: nursing home. ADL: activities of daily living. LTC: long-term care.

100 per cent. Generally speaking, the methodological quality of the articles is appropriate: the mean quality score is 82.9 per cent and 19 articles score 100 per cent. Column 5 shows us the designs ('D'). Qualitative designs (23 articles, 65.7%) were used most frequently, followed by quantitative (nine articles, 25.7%) and mixed-methods designs (three articles, 8.6%). Interviewing (22) is the method most used. In three articles, these interviews are combined with questionnaires and one of the interview studies is combined with a document review. There are ten questionnaire studies, of which two combined the questionnaire with observations. The other methods used in the articles are observation (two) and action research (one). Seven articles evaluated the effect of interventions on autonomy. In 32 of the 35 articles (*see* column 5, 'P'), the perspective of the resident was explored.

Description of autonomy in the included articles

For a better understanding of the facilitators and barriers to autonomy, the authors first aim to underpin the concept of autonomy for residents with physical impairments. The word autonomy is used in 16 articles (*see* column 6, description of autonomy, in Table 3). The polarity of decisional and executional autonomy (Collopy, 1988) was mentioned in four articles (Hwang *et al.*, 2006; Sikorska-Simmons, 2006; Hellström and Sarvimäki, 2007; Hillcoat-Nallétamby, 2014). Most of the other included articles only used one element of the polarity, the decisional aspect.

Autonomy, self-determination and dignity seem to be linked. Various relationships between these concepts were described in the included articles, as causes, intermediate factors or outcomes of one another. For example, dignity as a cause for autonomy (Nåden *et al.*, 2013). Also, an opposite perspective is mentioned: autonomy, amongst other aspects, leads to dignity (Hall *et al.*, 2014). Dignity as a result of choice and autonomy is also described (Oosterveld-Vlug *et al.*, 2014). Three articles use the motivational theory of Ryan and Deci (2000): in this theory, autonomy leads to self-determination (Custers *et al.*, 2010, 2011, 2012). Self-determination is also seen as a sub-category of autonomy (Hellström and Sarvimäki, 2007).

Based on the elements from column 6 of Table 3 (description of autonomy), a description of autonomy was formulated in such a way that it best matches the population in this review: older residents with physical impairments in RCFs. In the current article, autonomy is described as a capacity to influence the environment (Knight *et al.*, 2011; Lee *et al.*, 2013; Sæteren *et al.*, 2016) and make decisions (Bolmsjö *et al.*, 2006; Hwang *et al.*, 2006; Sikorska-Simmons, 2006; Hellström and Sarvimäki, 2007; Walent and Kayser-Jones, 2008; Andresen *et al.*, 2009; Cooney *et al.*, 2009; Anderberg and Berglund, 2010; Custers *et al.*, 2010, 2011, 2012; Knight *et al.*, 2010; Dunworth and Kirwan, 2012; Morgan and Brazda, 2013; Nåden *et al.*, 2013; Gleibs *et al.*, 2014; Hall *et al.*, 2014; Hillcoat-Nallétamby, 2014; Johnson and Bibbo, 2014), irrespective of having executional autonomy (Hillcoat-Nallétamby, 2014), to live the kind of life someone desires to live (Bolmsjö *et al.*, 2006; Walent and Kayser-Jones, 2008; Andresen *et al.*, 2009; Custers *et al.*, 2010, 2011, 2012; Knight *et al.*, 2010; Johnson and Bibbo, 2014; Sæteren *et al.*, 2016; Walker and Paliadelis, 2016) in the face of diminishing social, physical and/or cognitive resources and dependency (Morgan and Brazda,

2013; Sæteren *et al.*, 2016), and it develops in relationships (Bolmsjö *et al.*, 2006; Knight *et al.*, 2010; Abma *et al.*, 2012; Baur and Abma, 2012; Lagacé *et al.*, 2012; Oosterveld-Vlug *et al.*, 2013, 2014; Palacios-Ceña *et al.*, 2013; Sæteren *et al.*, 2016; Walker and Paliadelis, 2016).

Facilitators and barriers to autonomy of older adults with physical impairments in RCFs

The results of the literature review are organised into four themes of which characteristics of residents is the first theme. This theme is based on the included literature that provided rich information on the older adults themselves. The other themes are derived from the PCC framework: prerequisites of professional caregivers in RCFs, processes in the relationship between residents and professional care-givers, and the care environment (McCormack and McCance, 2017). Often the results reveal an ambiguity: aspects can either be facilitators or barriers. These will be elaborated on below, starting with the resident characteristics.

Characteristics of residents: facilitators

First, psycho-social characteristics of residents were identified (Table 4). Visits from family and friends help older adults to experience a sense of continuity of the life they lived before moving into the RCF (Hillcoat-Nallétamby, 2014). As a consequence of these visits, the valued roles they used to have for family and friends can be maintained. This offers a sense of belonging and autonomy (Hwang *et al.*, 2006; Chao *et al.*, 2008; Walent and Kayser-Jones, 2008; Cooney *et al.*, 2009; Oosterveld-Vlug *et al.*, 2014). If older adults have financial resources, possibilities are created to make decisions on spending money and having choice and control in their lives in RCF (Chao *et al.*, 2008; Gleibs *et al.*, 2014; Hillcoat-Nallétamby, 2014). The presence of meaningful activities can give control and social engagement. Through these activities, older adults can help each other and, as a result, have useful recognised roles (Danhauer *et al.*, 2006; Walent and Kayser-Jones, 2008; Custers *et al.*, 2012; Gleibs *et al.*, 2014; Hillcoat-Nallétamby, 2014; Råholm *et al.*, 2014).

Also, diverse intrapersonal characteristics are distinguished. Coping skills, which older adults developed earlier in their life history, lead to more control over the situation and autonomy (Hwang *et al.*, 2006; Curtiss *et al.*, 2007; Cooney *et al.*, 2009; Anderberg and Berglund, 2010; Custers *et al.*, 2010; Brandburg *et al.*, 2013; Oosterveld-Vlug *et al.*, 2013, 2014; Donnelly and MacEntee, 2016; Walker and Paliadelis, 2016). Relations with staff are important for exercising autonomy. In these relationships, older adults' need to be regarded as worthwhile persons can be fulfilled. Especially when residents lack family and friends who can act as advocates, relations with staff become more important (Chao *et al.*, 2008; Walent and Kayser-Jones, 2008; Oosterveld-Vlug *et al.*, 2013, 2014; Gleibs *et al.*, 2014; Hillcoat-Nallétamby, 2014). The possibility of deciding themselves about moving into the facility seems to have a positive impact on the feeling of autonomy and control (Chao *et al.*, 2008; Lee *et al.*, 2013; Morgan and Brazda, 2013; Johnson and Bibbo, 2014).

Table 4. Characteristics of residents

Facilitators	Barriers
Psycho-social characteristics:	
<ul style="list-style-type: none"> • Having financial resources • Helping family and friends • Relations with staff • Group activities • Social engagement • Helping each other 	<ul style="list-style-type: none"> • Absence of family and friends • Over-helping by others • Incongruent support • Leaving behind a husband or wife • Not complaining • Interpreting that staff are too busy
Intrapersonal characteristics:	
<ul style="list-style-type: none"> • Having a sense of meaning • Continuity of identity • Awareness • Coping abilities • Learning abilities • Uplifts • Taking responsibility • Educational level • Decision-making on moving • Information seeking • Optimism and hope • Mastering life in the institution and the wisdom to accept • Positive attitude • Feeling of being in control • Cognitive functions 	<ul style="list-style-type: none"> • Being unable to make decisions on moving • Sense of ineffectiveness • Acceptance of rules instead of questioning them
Physical functioning:	
<ul style="list-style-type: none"> • Residential care facility offers protection 	<ul style="list-style-type: none"> • Diminished ability to communicate • Being dependent

The last characteristic of the residents is the level of physical functioning. A higher level results in more control and choice in activities. Also, there is a higher use of living and other spaces in the RCF. In addition, there are more possibilities for going out (Hwang *et al.*, 2006; Chao *et al.*, 2008; Oosterveld-Vlug *et al.*, 2013; Hillcoat-Nallétamby, 2014).

Characteristics of residents: barriers

As said before, the aspects reveal an ambiguity, they can either be facilitator or barrier. The barriers are now given for the same aspects as above.

Psycho-social characteristics were identified, such as the absence of family and friends. In addition, being over-helped by others or receiving incongruent support are barriers to autonomy (Walent and Kayser-Jones, 2008; Morgan and Brazda, 2013; Oosterveld-Vlug *et al.*, 2014). If older adults do not have family and friends, they have to rely on staff or other residents for attention and help. Often older

adults hesitate to state their wishes and needs. They suppose that staff are too busy. Sometimes older adults assume that complaining or asking for help will have a negative effect on the care they receive (Bolmsjö *et al.*, 2006; Hellström and Sarvimäki, 2007; Walent and Kayser-Jones, 2008; Cooney *et al.*, 2009; Lagacé *et al.*, 2012; Morgan and Brazda, 2013; Donnelly and MacEntee, 2016).

Barriers in the intrapersonal characteristics, such as being unable to participate in the decision-making process of moving into the RCF, affect autonomy negatively (Chao *et al.*, 2008; Cooney *et al.*, 2009; Johnson and Bibbo, 2014; Lee *et al.*, 2013). Furthermore, shared decision-making is not taken for granted, because rules and time schedules are often accepted by older adults (Hellström and Sarvimäki, 2007; Chao *et al.*, 2008; Walent and Kayser-Jones, 2008; Lee *et al.*, 2013; Morgan and Brazda, 2013; Johnson and Bibbo, 2014; Donnelly and MacEntee, 2016; Sæteren *et al.*, 2016; Walker and Paliadelis, 2016).

In physical functioning, as the last characteristic of residents, barriers are also found. Immobility and a diminished ability to communicate might act as barriers. A lack of energy can interfere with residents being able to live the lives they want to live (Hellström and Sarvimäki, 2007; Walent and Kayser-Jones, 2008; Oosterveld-Vlug *et al.*, 2013, 2014; Gleibs *et al.*, 2014).

Prerequisites of professional care-givers in RCFs: facilitators

The second theme used to organise the results is the prerequisites of professional care-givers in RCFs (Table 5). The awareness of beliefs and values is established as prerequisite. Staff who are able to provide good professional care and are able to build high-quality relationships with residents help to preserve autonomy. So do staff who are able to treat residents with respect. The ability to take care of the physical appearance of residents also enhances autonomy (Custers *et al.*, 2011; Oosterveld-Vlug *et al.*, 2014; Råholm *et al.*, 2014).

More highly educated nurses, and nurses in higher positions, seem to be more capable of supporting autonomy. They are more reflective in their attitude and have fewer ageist assumptions (Dunworth and Kirwan, 2012).

Also, ethical competence and creativity of the staff are seen as facilitating autonomy (Bolmsjö *et al.*, 2006; Hall *et al.*, 2014).

Prerequisites of professional care-givers in RCFs: barriers

Barriers are also seen in the prerequisites. Dissatisfaction with the job and lack of ethical competence are barriers to autonomy. Negative beliefs and values such as ageist assumptions in staff, expressed in ageist communication and adverse relationships, are also barriers to autonomy (Bolmsjö *et al.*, 2006; Dunworth and Kirwan, 2012; Gleibs *et al.*, 2014; Hall *et al.*, 2014). An example of unethical behaviour in staff is seen when tables in the dining rooms are allocated as a punishment or reward for certain behaviours of older adults, thus leaving residents no choice of dinner companions (Palacios-Ceña *et al.*, 2013). Another threat to autonomy is undignified care, like forced-feeding situations (Nåden *et al.*, 2013).

Often encounters between staff and residents are scarce and show a lack of reciprocity. The last aspect in this theme is that staff seem unable to identify the

Table 5. Prerequisites of professional care-givers in residential care facilities

Facilitators	Barriers
Beliefs and values:	
<ul style="list-style-type: none"> The ward covers a set of positive values which is reflected in the actions of staff 	<ul style="list-style-type: none"> Ageist assumptions Stereotyping and stigmatising Absence of underlying values
Relationship:	
<ul style="list-style-type: none"> High-quality, caring relationships 	<ul style="list-style-type: none"> Coercing relationships: punishing, rewarding
Commitment to the job:	
<ul style="list-style-type: none"> Higher educational level or job function 	<ul style="list-style-type: none"> No satisfaction with the job
Ethical competence:	
<ul style="list-style-type: none"> Reflection Creativity 	<ul style="list-style-type: none"> Talking about choice but not acting upon it Not reacting to individuals' needs
Communication skills:	
<ul style="list-style-type: none"> Confirming communication 	<ul style="list-style-type: none"> Ageist communication

underlying messages in the communication. This can lead to an unfulfilled desire for autonomy (Bolmsjö *et al.*, 2006).

Processes in the relationship between residents and professional care-givers: facilitators

Communication is the first aspect that is distinguished in the processes between residents and care-givers (Table 6). Staff who have a good relationship with the older adults contribute to their need fulfilment. So do respectful communication and care for their physical appearance (Custers *et al.*, 2010).

Relations between residents and staff can reveal how diverse adaptive strategies are applied by older adults to have a life of their own in the RCF. Knowing and working with these individual strategies facilitates autonomy and assists older adults in dealing with problems (Andresen *et al.*, 2009; Brandburg *et al.*, 2013).

Table 6. Processes in the relation between residents and professional care-givers

Facilitators	Barriers
Communication:	
<ul style="list-style-type: none"> • Shared decision-making 	<ul style="list-style-type: none"> • Talking about persons • Persuasion
Relations:	
<ul style="list-style-type: none"> • Friendly, trustful relationships • Respecting and knowing the person and her or his past • Reinforcing, empowering • Reciprocity 	<ul style="list-style-type: none"> • No information and choice • Conflicts
Care-giving:	
<ul style="list-style-type: none"> • Giving space • Individual tailored programmes 	<ul style="list-style-type: none"> • Prioritising physical care • Having to wait, ignoring • Physical humiliations

Staff can find out what autonomy means for older adults by listening to life stories. These stories reflect the values of older adults in life, their personal identity and relations (Abma *et al.*, 2012). With an empowering strategy, involvement in care and shared goals can be realised and ownership is enhanced (Baur and Abma, 2012; Sæteren *et al.*, 2016).

Processes in the relationship between residents and professional care-givers: barriers

The lack of constructive communication can act as a barrier to autonomy. For example, when staff use routines, or impose activities of care or let older adults wait for help (Nåden *et al.*, 2013; Palacios-Ceña *et al.*, 2013; Oosterveld-Vlug *et al.*, 2014; Donnelly and MacEntee, 2016). The possibility of participating in decision-making can be hindered by a lack of information and choice (Hellström and Sarvimäki, 2007; Walent and Kayser-Jones, 2008). Furthermore, conflicts with staff might discourage older adults from expressing their wants and needs (Walent and Kayser-Jones, 2008; Lagacé *et al.*, 2012; Hall *et al.*, 2014).

Care environment: facilitators

The last theme to organise the results is the care environment (Table 7). RCFs that have high levels of choice-enhancing policies and have adequate staff seem to increase the residents' autonomy. Also, financial resources and a conforming

Table 7. Care environment

Facilitators	Barriers
Choice and control:	
<ul style="list-style-type: none"> • Formal involvement in decision-making • Supportive systems 	<ul style="list-style-type: none"> • Schedules and regulations • Lack of choice • Organisational decisions instead of professional
Staffing:	
<ul style="list-style-type: none"> • Skilled personnel • Continuity of staff • Ethnical and cultural congruity • Background of management 	<ul style="list-style-type: none"> • Inadequate staffing • Deployment of temporary personnel
Physical and financial environment:	
<ul style="list-style-type: none"> • Shared and private spaces 	<ul style="list-style-type: none"> • Lack of resources • Little or shared physical space • House is not a home

physical outline seem to act as facilitators (Sikorska-Simmons, 2006; Walent and Kayser-Jones, 2008; Knight *et al.*, 2010). For example, the management can support the participation of older adults in organisational choices, such as selection of menu, gardening and social activities. This enhances the sense of mastery (Knight *et al.*, 2011; Baur and Abma, 2012; Lee *et al.*, 2013). Another example is the employment of skilled and permanent staff who share the same language, which facilitates autonomy (Walent and Kayser-Jones, 2008; Cooney *et al.*, 2009; Custers *et al.*, 2011; Walker and Paliadelis, 2016; Dunworth and Kirwan, 2012). A combination of appropriate shared and private spaces for older adults enhances choice, feelings of safety and participation (Chao *et al.*, 2008; Hall *et al.*, 2014; Hillcoat-Nallétamby, 2014; Johnson and Bibbo, 2014).

Care environment: barriers

A lack of choice and control in daily life, such as the use of schedules, is found as a barrier. These schedules force older adults to fit their lives into routines, which might undermine autonomy. Also, routines for activities such as morning procedures, meals, washing, going to the toilet and bedtimes can act as barriers to autonomy (Curtiss *et al.*, 2007; Andresen *et al.*, 2009; Hall *et al.*, 2014; Johnson and Bibbo, 2014).

Understaffing and employment of temporary employees can be barriers to autonomy. There is no time to get acquainted, to build relationships and to get to know the preferences of residents (Walent and Kayser-Jones, 2008; Hall *et al.*, 2014; Oosterveld-Vlug *et al.*, 2014).

Shortages in resources due to directives and political decisions is one of the causes of understaffing. This affects autonomy because there are fewer staff to respond to older adults' needs (Hellström and Sarvimäki, 2007; Gleibs *et al.*, 2014). The physical outline of the building and decoration of the rooms influence the experience of feeling at home. RCFs that appear like a hospital have a non-confirming atmosphere (Cooney *et al.*, 2009; Lagacé *et al.*, 2012; Näden *et al.*, 2013; Gleibs *et al.*, 2014; Oosterveld-Vlug *et al.*, 2014).

Discussion

The current literature review was executed to gain more insight into facilitators and barriers to autonomy of residents with physical impairments living in RCFs. Based on the literature search and the subsequent synthesis of the data of the included articles, the facilitators and barriers to autonomy were identified and organised. Three themes were based on the framework of PCP (McCormack and McCance, 2017). Particular aspects in the care environment act as barriers to autonomy. Relationships between staff and residents can either facilitate or inhibit autonomy, depending on the prerequisites of the care-givers and characteristics, *e.g.* coping skills, of the residents.

Although the framework includes elements of PCP, the care recipient her- or himself is not present in the model. In the current review, characteristics of residents that influence autonomy were determined. The theme 'characteristics of residents' is added to arrange the results of the older adults. The majority of the articles investigated this perspective, so a large set of attributes of residents that influence autonomy were distinguished.

Facilitators and barriers to autonomy can be allocated to elements of the PCP framework. The macro context, which contains aspects such as health policies and strategic frameworks, is not investigated in the included articles. The PCP framework seems to encompass all the distinguished influencing aspects for autonomy in the included articles. The culture change to more person-centred care can enhance autonomy. Realising a culture change in RCFs, however, is difficult with so many challenges to deal with (Donnelly and MacEntee, 2016).

Based on the descriptions of the included articles, a description of autonomy was formulated. The authors established this description because it compiles the core elements of autonomy for older adults with physical impairments living in RCFs, as used in the included articles. Autonomy is described as a capacity to influence the environment (Knight *et al.*, 2011; Lee *et al.*, 2013; Sæteren *et al.*, 2016) and make decisions (Bolmsjö *et al.*, 2006; Hwang *et al.*, 2006; Sikorska-Simmons, 2006; Hellström and Sarvimäki, 2007; Walent and Kayser-Jones, 2008; Andresen *et al.*, 2009; Cooney *et al.*, 2009; Anderberg and Berglund, 2010; Custers *et al.*, 2010, 2011, 2012; Knight *et al.*, 2010; Dunworth and Kirwan, 2012; Morgan and Brazda, 2013; Näden *et al.*, 2013; Gleibs *et al.*, 2014; Hall *et al.*, 2014; Hillcoat-Nallétamby, 2014; Johnson and Bibbo, 2014), irrespective of having executional autonomy (Hillcoat-Nallétamby, 2014), to live the kind of life someone desires to live (Bolmsjö *et al.*, 2006; Walent and Kayser-Jones, 2008; Andresen *et al.*, 2009; Custers *et al.*, 2010, 2011, 2012; Knight *et al.*, 2010; Johnson and Bibbo, 2014; Sæteren *et al.*, 2016; Walker and Paliadelis, 2016) in the face of

diminishing social, physical and/or cognitive resources and dependency (Morgan and Brazda, 2013; Sæteren *et al.*, 2016), and it develops in relationships (Bolmsjö *et al.*, 2006; Knight *et al.*, 2010; Abma *et al.*, 2012; Baur and Abma, 2012; Lagacé *et al.*, 2012; Oosterveld-Vlug *et al.*, 2013, 2014; Palacios-Ceña *et al.*, 2013; Sæteren *et al.*, 2016; Walker and Paliadelis, 2016).

Based on the included articles, the description focuses on decisional and relational autonomy. This might be explained because the literature search was performed for physically impaired older adults living in RCFs. These residents are generally able to make choices, but physical impairments can obstruct the execution of the decisions taken. They often need practical help from others to carry out their decisions. Also, the relational aspect was prominent in the included articles, which can be related to the fact that living in an RCF means living with other residents and staff, and thus in relation to others.

The aspect of forced autonomy, using force to make decisions and act upon them independently, was not present in the included articles. However, paternalism was present: making choices for persons who are able to make decisions on their own.

Nonetheless, we found barriers to autonomy related to force, for example the forced use of services, such as eating, following regulations, transfer to the residential care, and transfer of tasks and responsibilities. Autonomy, in the included articles, is often hindered by care-givers and institutions, and is not forced upon residents (Hwang *et al.*, 2006; Hellström and Sarvimäki, 2007; Knight *et al.*, 2011; Dunworth and Kirwan, 2012; Lagacé *et al.*, 2012; Oosterveld-Vlug *et al.*, 2014).

Strengths

In this review, results from articles that focus on dignity, self-determination and autonomy are aggregated. The different positions in the relationships between the three concepts and their intertwined use in the included articles made it rewarding to merge all facilitators and barriers. As a result of the merging, the review offers a comprehensive overview of factors that influence autonomy of residents with physical impairments living in RCFs.

The execution of the systematic review by four of the five authors was established first independently and later through meetings to achieve a uniform procedure at the start of each stage of the selection, quality assessment and data extraction. The first author assessed all articles. Three of the co-authors reviewed a selection of the articles. At each stage of the selection process, consensus was reached about inclusion or exclusion of articles by means of bilateral discussions.

Limitations

A limitation in organising the results according to the PCP framework is that some of the included articles lack specific information, so the allocation of a facilitator or barrier can be difficult. For example, the framework makes a distinction between being prepared for the job (prerequisites) and delivering care (person-centred processes). However, there is not enough information in the included articles about preparation for the job or educational background. The consequence is that it is difficult to allocate results such as communication to either prerequisites

(communication skills) or care processes (communication). The same can be said for building relationships (prerequisite) and relations (care processes). In that case, barriers and facilitators were allocated to both themes, so a repetition is seen.

In this study, the authors aimed to include residents with physical impairments. However, it cannot be certain that persons with dementia were totally excluded because of the lack of precise information about the assessment of mental status. The content of the articles, however, gives confidence that the research is not done on persons with moderate or severe dementia.

The same can be said for the inclusion of persons with an average age of 65 years. The authors screened the articles thoroughly to exclude studies on residents under 65 years. However, if some individuals under this age participated in the studies, the authors calculated the mean age. The mean in all these articles was 77 years or more. This mean of 77 was used as a rationale to include the article as describing residents above 65 years. For three included articles, the authors were not able to calculate a mean age because the individual ages of the participants were not given. However, an age range of 49–102 (Oosterveld-Vlug *et al.*, 2013), 62–103, (Sæteren *et al.*, 2016) and 60–100 (Lagacé *et al.*, 2012) was provided for the participants of their studies. The subject of the articles gives us the assurance that the group had age-related impairments.

Implications for practice and science

The current review leads to a better understanding of autonomy-enhancing elements for residents with physical impairments in RCFs. Autonomy is a broad, complex, multifaceted and relational concept that can be influenced by many factors in various ways. The results have implications for practice for both residents and care-givers, because they offer possibilities to preserve and enhance autonomy. The knowledge of facilitators and barriers established in this review can be used in the education of current and future nurses or other care personnel to make them aware of how to enhance autonomy. Based on the results in all four themes, RCFs can systematically develop autonomy-enhancing practices.

Scientifically, this study creates new knowledge and provides an actual overview on autonomy for older adults with physical impairments in RCFs and how to support autonomy. The results accentuate the influence of multiple aspects to achieve autonomy in RCFs.

More empirical research should be done on autonomy in practice. What significance does autonomy have for residents and staff and when is autonomy (not) enhanced or perhaps forced? Do we recognise (parts of) the description of autonomy in daily care practice? Because autonomy is a complex, relational and dynamic concept, it can best be investigated through observational methods that examine the perspectives of residents and care-givers. Shadowing is a method that can be used in an environment where autonomy is manifested, *e.g.* in RCFs (van der Meide *et al.*, 2015). Research can give insight into how factors established in this review interrelate and how they are expressed in the care process. It is advisable to investigate dimensions of the concept of autonomy other than executional and decisional autonomy which dominate in the results of this systematic review. It is possible that important aspects of autonomy – *e.g.* the relational aspect of autonomy – are

getting less attention or can be overlooked if further research restricts itself to this polarity. More attention should also be paid to the facilitators and barriers in the macro context. RCFs are strongly dependent on government health policies and funding to achieve autonomy-enhancing practices.

Furthermore, the knowledge can be used in participatory transformational action research. Action groups with different stakeholders in RCFs can experiment with actions to strengthen autonomy. In this way, the perspectives of residents, care-givers and organisations can be studied in relation to each other. Supportive practices for autonomy can be identified and examined by means of this bottom-up development.

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