

Emergent institutional ageism and the protection-autonomy paradox in Romanian residential long-term care: a systems- informed qualitative documentary analysis

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Abstract

Background

Institutional ageism can be produced not only by explicit prejudice but also by rules and administrative arrangements that prioritize protection, standardization, and organizational accountability over supported choice. Regulatory documents are therefore an important site for examining how autonomy and participation are enabled or constrained in residential long-term care.

Methods

We conducted a qualitative documentary analysis of nine publicly available Romanian legal, regulatory, strategic, and administrative instruments governing social services and residential long-term care for older people. No human participants were included. The analyzed regulatory framework applies to “older persons” as legally defined in Romania, namely persons who have reached the statutory retirement age; no upper age limit is specified. Documents in force or operationally relevant on 31 July 2026 were retrieved from official government sources. A combined directed-inductive coding framework examined person-centredness, autonomy, consent, participation, family and representative involvement, risk management, daily-life choice, complaints, monitoring, and health-related safeguards. Findings were interpreted using a systems-informed framework.

Results

Five themes were identified: (1) explicit rights-based and person-centred commitments; (2) autonomy translated mainly into procedural acknowledgement, signatures, and acceptance of predefined plans; (3) substantially denser operational specification of safety, risk, documentation, and compliance than of everyday choice; (4) participation concentrated at the individual care-plan and feedback levels, with limited provisions for shared institutional governance; and (5) family or legal-representative involvement functioning as both a support and a potential substitute for the older person’s own voice. Across documents, these patterns generated a protection-autonomy paradox: the same regulatory architecture that protects residents may also create conditions in which benevolent institutional ageism can emerge during implementation.

Conclusions

Romanian long-term care regulation contains meaningful safeguards for rights and individualized support, but autonomy is less operationally developed than protection and accountability. Regulatory reform should add explicit requirements for supported decision-making, documentation of meaningful

options, resident influence over everyday routines, and participation in service governance. The proposed concept of emergent institutional ageism should be tested in comparative implementation studies.

Background

Ageism—stereotypes, prejudice, and discrimination directed at people because of age—is increasingly recognized as a social determinant of health and a contributor to inequalities in physical health, mental health, service access, social participation, and quality of life [1–5]. The World Health Organization has identified combating ageism as a central priority of the United Nations Decade of Healthy Ageing, emphasizing that age-related disadvantage is reproduced through interpersonal encounters, institutional arrangements, and wider social structures [1, 6, 7]. Structural and institutional forms are particularly important because they can influence large populations without requiring overt hostility or conscious discriminatory intent [2, 4, 5].

Residential long-term care is a critical setting in which these processes may operate. Older people enter residential services with diverse combinations of chronic illness, disability, bereavement, poverty, housing insecurity, limited family support, and care needs. Institutions must simultaneously provide safety, continuity, health-related support, social care, dignity, and opportunities for personal agency. Existing literature shows that autonomy in residential care depends not only on residents' functional abilities but also on staffing practices, organizational routines, environmental flexibility, communication, and the extent to which preferences are treated as actionable information [8–12]. Person-centred care can improve well-being and perceived quality, yet institutional routines can normalize passivity when residents are primarily represented as dependent, vulnerable, or at risk [10–13].

The tension between protection and autonomy is not a simple opposition. Safeguarding, clinical oversight, food safety, medication management, emergency response, and prevention of neglect are indispensable. However, protection can become paternalistic when restrictions are generalized, when risk is treated as a reason to remove choice rather than negotiate it, or when agreement is inferred from a signature without evidence that meaningful alternatives were offered. This pattern is often described as benevolent or compassionate ageism: conduct motivated by care or protection that nevertheless rests on assumptions of diminished competence and may reduce self-determination [1, 5, 14].

A systems perspective helps explain why such outcomes may occur even when individual professionals intend to provide respectful care. Long-term care is a complex system shaped by legislation, licensing rules, inspection practices, funding constraints, workforce capacity, family expectations, organizational procedures, and residents' health and social circumstances. Regulatory requirements determine what must be documented, measured, reviewed, and demonstrated during inspection. The dimensions that receive the greatest procedural detail can become organizational priorities, while less operationalized values may depend on local discretion and resources. Feedback processes may then reinforce initial assumptions: older people classified as vulnerable receive more protective control; fewer opportunities

for choice can reduce initiative; reduced initiative can be documented as dependency; and documented dependency can justify further control [15–19].

Romania provides a relevant context for examining this issue. Rapid population ageing, regional inequalities, labour migration, and the continuing development of formal long-term care have increased pressure on families and social services [20–23]. The national policy framework has changed substantially since 2022, including a long-term care and active ageing strategy, strengthened case-management requirements, new community-needs assessment procedures, a new model social-services contract, revised health authorization requirements, and a new national nomenclature and framework regulation entering into force in July 2026 [24–32]. These changes create an opportunity to assess whether the regulatory architecture translates broad commitments to person-centred care into concrete protections for autonomy and participation.

Regulatory and policy texts do not reveal how care is experienced in practice, and they cannot establish the prevalence of ageism. They do, however, define legitimate institutional action, allocate responsibilities, specify required records, and structure the evidence organizations must produce. Qualitative documentary analysis can therefore identify the assumptions, priorities, and implementation gaps embedded in the formal architecture of care [33–36].

This study aimed to examine how Romanian legal, regulatory, strategic, and administrative documents governing residential long-term care frame protection, autonomy, and participation. The research questions were: (1) How are older people represented as rights-holders, decision-makers, care recipients, and persons at risk? (2) Which aspects of autonomy and participation are translated into operational requirements? (3) How do the documents distribute authority among the older person, family members, legal representatives, professionals, providers, and public authorities? and (4) What system-level mechanisms may create conditions for benevolent or institutional ageism during implementation?

Methods

Study design

We used qualitative documentary analysis, combining manifest content mapping with interpretive thematic analysis [33–36]. The primary unit of analysis was the regulatory or policy provision, not an individual person, organization, or case. The study was systems-informed: documents were examined both for their explicit requirements and for the relationships they established among residents, families, professionals, providers, inspectors, and public authorities [15–19].

Document corpus and eligibility criteria

The corpus consisted exclusively of publicly available national documents issued by Romanian public authorities. Because the unit of analysis was the regulatory or policy document rather than individual

persons, the study did not include a human participant population and therefore no participant age range was applied. For the purposes of defining the population covered by the analyzed regulatory framework, “older persons” were understood according to Article 1(4) of Romanian Law no. 17/2000 as persons who have reached the statutory retirement age. No upper age limit is specified. Under current Romanian pension legislation, the standard retirement age is 65 years for both women and men, subject to the statutory transitional schedule. Documents were eligible when they: (1) directly governed social assistance or long-term care for older people; (2) contained provisions relevant to residential services, assessment, care planning, contracting, health and safety, quality assurance, participation, or service organization; and (3) were in force or operationally relevant on 31 July 2026. The cutoff date was selected because Government Decision no. 268/2026 entered into force on 1 July 2026 while temporarily retaining existing minimum quality standards until their formal revision [32].

We excluded documents concerned exclusively with financing formulas, employment conditions, clinical treatment protocols, or populations other than older people, unless they directly established requirements applied to residential older-person services. European Union and WHO documents were used as interpretive benchmarks but were not coded as part of the primary national corpus. The final corpus contained nine instruments (Table 1).

Table 1. Primary documentary corpus.

ID	Document	Date/status	Primary analytical relevance
D1	Social Assistance Law no. 292/2011, consolidated version	2011; consolidated to 2026	General rights, access, assessment, provider duties, involvement of older people and families
D2	Law no. 17/2000 on social assistance for older persons, republished	2000; republished 2024	Older-person entitlements, needs assessment, long-term care organization and representation
D3	Government Decision no. 1492/2022 and National Strategy for Long-Term Care and Active Ageing 2023–2030	2022	Strategic orientation, community care, active ageing, integrated long-term care
D4	Order no. 29/2019, Annex 1: minimum quality standards for residential services for older persons	2019; consolidated 2022; transitional use in 2026	Admission, personal files, assessment, individualized planning, rights, complaints, quality and inspection indicators
D5	Order no. 2489/2023: minimum quality standards for case management in services for older persons	2023	Person-centred case management, integrated assessment, planning, monitoring and risk management
D6	Order no. 1923/2024: framework methodology for community-needs assessment for older persons	2024	Population-level needs assessment and local service planning
D7	Order no. 1126/2025: framework social-services contract and monitoring instruments	2025	Contractual rights and duties, provider reporting and service monitoring
D8	Order no. 328/2025, as amended: health authorization requirements for residential centres for older persons	2025–2026	Spatial, hygiene, medical, safety and authorization requirements
D9	Government Decision no. 268/2026: social-services nomenclature and framework organizational regulation	2026; effective 1 July 2026	Current service classification, access, contracting, termination, functions and organizational responsibilities

Document retrieval and data management

Consolidated versions were retrieved from the official Romanian Legislative Portal between 4 and 6 August 2026. Document titles, issuing authorities, publication dates, amendment status, and stable web addresses were recorded in a corpus log. Relevant provisions were transferred into a structured extraction matrix with source identifiers and article, module, standard, or annex references. Because the corpus was public, no personal, confidential, or institution-specific documents were accessed.

Analytical framework

The initial coding framework was informed by the WHO definition of ageism, scholarship on structural ageism and autonomy in residential care, and international principles for high-quality long-term care [1–5,8–14,37]. It included nine domains: (1) personhood and rights; (2) information and consent; (3) supported decision-making and meaningful options; (4) participation in assessment and individualized planning; (5) influence over everyday life and institutional governance; (6) family and legal-representative involvement; (7) risk, safety, surveillance, and restriction; (8) complaints, accountability, and inspection; and (9) health, psychosocial well-being, and community inclusion. The full codebook is provided in Supplementary File 1; Supplementary File 2 contains the source-linked evidence matrix.

A directed-inductive approach was used. Provisions were first coded against the predefined domains, after which new codes were added when the documents contained concepts not adequately captured by the framework. Coding distinguished between aspirational language (for example, broad principles), procedural requirements (actions that providers must perform), evidentiary requirements (documents, signatures, registers, or indicators that must exist), and enforceable safeguards (requirements specifying how an older person's choice must influence a decision). This distinction was central to the analysis because a value may be formally recognized without being operationalized in a manner that changes institutional practice.

Analytic process and trustworthiness

Analysis proceeded in five stages. First, each document was summarized in terms of purpose, authority, target level, and implementation mechanism. Second, relevant provisions were coded line by line in the extraction matrix. Third, coded material was compared across documents to identify convergence, contradiction, and regulatory asymmetry. Fourth, candidate themes were developed around recurrent patterns in how protection, autonomy, and participation were operationalized. Fifth, the themes were interpreted as interacting system mechanisms rather than isolated legal provisions.

The analysis emphasized negative and qualifying evidence. Provisions that explicitly required resident preferences, agreement, access to records, complaints mechanisms, or the expression of a point of view were retained as counterweights to interpretations of paternalism. No numerical frequency analysis was used because documents differed substantially in length, legal function, and drafting style; regulatory density was assessed through the specificity and enforceability of provisions rather than raw word counts. An audit trail linked each thematic claim to exact provisions in the source matrix; the principal links are reported in Supplementary File 2. Reporting was guided by the Standards for Reporting Qualitative Research [36].

The authors approached the corpus from backgrounds in social work, social policy, and ageing research. Reflexive attention was given to the risk of treating all protective regulation as ageist. The analysis therefore defined institutional ageism narrowly: not as the existence of safeguarding requirements, but

as a potential system effect when age-linked vulnerability is used to normalize restrictions, substitute others' decisions for the person's own voice, or leave autonomy dependent on discretionary implementation.

Ethics and use of generative artificial intelligence

Ethics approval and consent were not required because the study analyzed only publicly available legal, regulatory, strategic, and administrative documents. No human participants, human data, personal records, case files, interviews, or identifiable information were accessed or analyzed. A generative artificial intelligence tool was used during manuscript preparation to support English-language editing, structural reformatting, and consistency checking. The authors are responsible for independently verifying the document corpus, coding, interpretations, references, and final manuscript.

Results

Overview

The documents did not present a uniformly paternalistic model. They contained substantial rights-based language, required individualized assessment and planning, and created mechanisms for information, consent, access to records, complaints, and quality monitoring. The central finding was instead an asymmetry in operational detail. Protection, eligibility, documentation, professional responsibility, health authorization, and regulatory compliance were specified through numerous concrete procedures and evidentiary requirements. Autonomy and participation were acknowledged, but were more often expressed through general principles, signatures, consultation, or acceptance of plans than through enforceable requirements for supported choice and shared control. Five themes captured this pattern (Table 2).

Theme 1: rights-based and person-centred commitments are explicit but distributed across the system

The corpus contained a clear normative commitment to older people as rights-holders. The Social Assistance Law establishes entitlement to social services, requires the involvement of the older person in the service process, and connects service provision to individual needs and circumstances [24]. The law specific to older persons frames social assistance as a right and establishes assessment and representation arrangements [25]. The national strategy emphasizes active ageing, community-based services, prevention of dependency, and integrated long-term care [26].

At service level, the minimum quality standards require information before admission, a service contract, an individual file, periodic assessment, individualized planning, the consideration of wishes or preferences, access to complaints procedures, and measures of satisfaction [27]. The case-

management standards add an explicit person-centred orientation and seek to reduce fragmentation through integrated assessment, planning, monitoring, and interinstitutional coordination [28]. Government Decision no. 268/2026 updates the service nomenclature and framework organizational regulation and mandates revision of the minimum quality standards, creating a timely opportunity to consolidate these safeguards [32]. These provisions are important safeguards and contradict any claim that Romanian regulation simply ignores autonomy.

However, rights-related provisions are distributed across general laws, quality standards, contracts, case-management instruments, and organizational regulations. Their effectiveness therefore depends on coordination across multiple actors and on translation into local procedures. No single instrument consolidates a comprehensive operational standard for supported autonomy in residential life. The system formally recognizes person-centredness, but responsibility for making it concrete remains fragmented.

Theme 2: autonomy is translated mainly into procedural acknowledgement and acceptance

Across the corpus, autonomy was most consistently operationalized through information, signatures, consultation, and documented acceptance. Admission requires an application and contract; individualized plans contain a signature or acknowledgement field; services are established with the agreement of the beneficiary or representative; and termination decisions must be communicated [24,25,27,30,32]. These procedures protect against completely unilateral decision-making and create an auditable record of formal involvement.

Nevertheless, the documents provide less detail on the quality of the decision-making process. They rarely require providers to document which options were offered, how information was adapted to communication or cognitive needs, whether the person understood the consequences, how disagreement was addressed, or how a preferred option was implemented. A signature can therefore demonstrate that a document was presented without demonstrating that the person exercised meaningful control. Similarly, the requirement to consider wishes or preferences does not consistently specify what happens when preferences conflict with routines, staffing capacity, family views, or professional risk judgments.

This proceduralization matters because residential-care decisions are often relational and repeated rather than one-off contractual choices. Autonomy concerns waking and sleeping times, food, clothing, privacy, visitors, movement, participation in activities, personal possessions, religious practice, use of money, and acceptable risk. These domains were less consistently translated into specific provider obligations than assessment, contracting, service scheduling, and record maintenance. The documentary architecture thus protects formal consent more clearly than everyday self-determination.

Theme 3: protection, risk, and accountability receive denser operational specification than everyday choice

The strongest procedural density concerned safety and accountability. The quality standards specify admission documents, confidential file storage, assessment and reassessment schedules, individualized plans, staff responsibilities, complaints records, quality indicators, and inspection evidence [27]. Case-management standards include a dedicated module for risk situations and formal coordination duties [28]. Health authorization rules detail spatial organization, hygiene, medical and care areas, food-related requirements, and operational conditions [31]. The new framework regulation structures access, contracting, service functions, provider responsibilities, termination, and reporting [32].

These requirements are necessary responses to real risks in residential care. The potential problem is not their existence, but the lack of equivalently detailed standards for negotiated risk and positive autonomy. The documents provide limited operational guidance for distinguishing between an unacceptable hazard and a risk that a competent resident may reasonably choose. They do not establish a standard process for documenting proportionality, less restrictive alternatives, time-limited restrictions, or review with the person affected. As a result, local organizations may find it easier to demonstrate compliance through prevention and control than through carefully supported risk-taking.

This asymmetry can create a protection-autonomy paradox. Providers are accountable for adverse events and visible failures of safety, while losses of agency, spontaneity, identity, or meaningful participation are harder to measure and less likely to generate immediate regulatory consequences. Organizationally rational responses may therefore favor standardized routines. When applied broadly to older residents because they are categorized as vulnerable or dependent, such responses can reproduce benevolent ageism without explicit discriminatory intent.

Theme 4: participation is concentrated in personal planning and feedback, not shared institutional governance

The documents recognize participation primarily at three points: involvement in personal assessment and planning, acknowledgement of contracts and plans, and the opportunity to express dissatisfaction through complaints or satisfaction instruments [24,27,28,30,32]. These mechanisms are valuable because they create channels through which residents can influence their own services and challenge poor quality.

However, participation is less developed at the collective and organizational levels. The corpus contained limited concrete requirements for resident councils, co-design of institutional rules, shared decisions about activity schedules and communal routines, participation in quality-improvement committees, or routine publication of how resident feedback changed practice. Consultation is therefore more visible as an individual or reactive mechanism than as an element of institutional governance.

The distinction is important. A person may sign an individualized plan while having little influence over the institutional environment within which that plan is delivered. Where meal times, staffing patterns, visitor rules, activity timetables, and mobility arrangements are fixed at organizational level, individual preferences can only operate within predefined boundaries. Regulatory recognition of participation may consequently coexist with limited resident power over the rules that shape daily life.

Theme 5: family and legal-representative involvement can support or displace the older person's voice

Romanian legislation appropriately recognizes that family members, informal carers, and legal representatives may be essential to assessment, continuity of care, communication, and protection [24,25,28]. In contexts of migration, disability, cognitive impairment, or complex care needs, such involvement can preserve relationships and provide practical support. The national framework also seeks better coordination between public services, providers, and family resources [26,28,29].

At the same time, several provisions use formulations such as “beneficiary or legal representative,” and service processes may be completed through a representative when applicable [25,27,28,30,32]. The corpus did not consistently specify a hierarchy requiring direct engagement with the older person to the greatest possible extent, even when a representative participates. Nor did it consistently distinguish legal incapacity from communication difficulty, dependency, or family convenience. Without supported-decision safeguards, representative involvement may unintentionally become substitution rather than assistance.

This is a key mechanism of benevolent institutional ageism. Family or professional decisions may be motivated by concern, yet still silence a person who retains preferences and decision-making abilities. The regulatory framework would be strengthened by explicit duties to presume capacity, communicate directly with the resident, document the resident's will and preferences, and use representation only within its lawful scope.

Systems synthesis: emergent institutional ageism

Taken together, the themes support a systems-level proposition rather than a conclusion that any single law or provider is ageist. Broad rights commitments enter an implementation environment in which providers face concrete obligations to prevent harm, maintain records, satisfy licensing criteria, coordinate professionals, and demonstrate compliance. Autonomy is present but less operationally specified. Under workforce or resource constraints, the most measurable obligations are likely to dominate organizational attention.

We define emergent institutional ageism as age-related constraints on autonomy and participation that arise from the interaction of protective regulation, administrative routines, professional risk

management, representation practices, and resource limitations, even when no actor intends to discriminate. The potential reinforcing loop is: classification of vulnerability leads to protective standardization; standardization reduces opportunities for initiative and negotiated risk; reduced initiative is interpreted or recorded as dependency; and dependency legitimizes further protective control. This is an analytic model to be tested, not evidence that the loop occurs uniformly across Romanian facilities.

Table 2. Themes, system mechanisms, and regulatory leverage points.

Theme	Documentary pattern	Potential system mechanism	Leverage point
Rights-based commitments	Rights, person-centredness, individualized assessment, preferences, complaints and involvement are formally recognized.	Fragmented responsibility across laws, standards, contracts and providers.	Consolidate an enforceable autonomy standard across instruments.
Proceduralized autonomy	Signatures, acknowledgement, consultation and acceptance are more specified than meaningful choice processes.	Formal compliance may substitute for supported decision-making.	Require documentation of options, communication support, disagreement and implementation of preferences.
Protection-autonomy asymmetry	Safety, risk, health authorization, records and inspection evidence are densely operationalized.	Providers face stronger incentives to prevent visible harm than to preserve positive autonomy.	Introduce proportionality, least-restrictive alternatives, negotiated risk and mandatory review.
Limited shared governance	Participation centres on personal plans, complaints and satisfaction feedback.	Residents influence individual services more than institutional rules and routines.	Require resident councils, co-design, feedback-to-action reporting and governance participation.
Representative substitution risk	Family and representatives facilitate care but may become substitute decision-makers.	Dependency or communication difficulty may be conflated with incapacity.	Presume capacity, prioritize direct communication and document will and preferences.

Discussion

Principal findings

This documentary analysis identified a regulatory framework that is neither simply rights-based nor simply paternalistic. Romanian law and policy contain meaningful commitments to individualized care, information, consent, involvement, complaints, active ageing, and community support. The central issue is an implementation asymmetry: protective and administrative obligations are more specific, measurable, and inspectable than supported choice, everyday autonomy, and shared governance. This asymmetry may create conditions for benevolent institutional ageism when organizations translate vulnerability into generalized control.

The findings align with research showing that autonomy in residential care is shaped by relationships and organizational structures rather than by functional capacity alone [8, 9]. Residents' choices may be narrowed by fixed routines, staff interpretations of safety, and assumptions about dependency [10–13]. Structural-ageism scholarship similarly emphasizes that disadvantage can be reproduced by policies and institutions without overtly prejudiced actors [2, 4, 5]. Our analysis adds a regulatory mechanism: values that are weakly operationalized can be displaced by requirements that are more auditable and carry clearer organizational consequences.

The protection-autonomy paradox and health

The protection-autonomy paradox has direct relevance to health. Safety, medical support, nutrition, hygiene, and prevention of abuse are fundamental components of quality care. Yet autonomy, social participation, identity continuity, and meaningful relationships are also determinants of psychosocial well-being and functional ability [6–9, 38–41]. A regulatory system that treats these dimensions as secondary may protect residents from some harms while increasing loneliness, passivity, or loss of purpose. The present study cannot establish such outcomes, but it identifies a plausible institutional pathway that should be investigated empirically.

The distinction between negative and positive autonomy is useful. Negative autonomy concerns protection from coercion and unjustified interference; positive autonomy concerns the practical ability to make and enact choices with appropriate support. The documents contain important negative safeguards—contracts, information, complaints, confidentiality, and procedural review—but fewer requirements ensuring that residents have realistic options, communication support, and influence over daily routines. High-quality long-term care requires both.

Implications for regulation, inspection, and practice

First, minimum quality standards should define supported decision-making as a core care process. Providers could be required to document the person's preferred communication method, options discussed, assistance provided, the resident's expressed will and preferences, reasons for any departure from those preferences, and the date for review. A signature alone should not be treated as sufficient evidence of participation.

Second, inspection frameworks should assess everyday autonomy. Indicators could cover control over waking and sleeping, food choices, clothing, privacy, visitors, movement, personal possessions,

activities, religious or cultural practices, and access to the community. Inspectors should examine whether routines are individualized in practice, not only whether a plan exists.

Third, risk-management requirements should incorporate proportionality and least-restrictive alternatives. Restrictions should be linked to a specific, documented risk; discussed with the person; limited in scope and duration; reviewed regularly; and replaced when a less restrictive approach is feasible. Positive risk-taking should be recognized as part of person-centred care rather than as regulatory failure.

Fourth, participation should extend beyond complaints and satisfaction questionnaires. Resident councils, co-production of house rules, involvement in recruitment and quality-improvement processes, and public reporting of actions taken in response to resident feedback would shift participation from consultation toward shared governance.

Fifth, family and representatives should be integrated through a clear supported-decision hierarchy. The older person should be addressed directly and involved to the greatest possible extent. A representative's role, legal authority, and relationship to the person's expressed will should be documented. Dependency, sensory impairment, or communication difficulty should not be treated as evidence of incapacity.

Finally, the transition created by Government Decision no. 268/2026 provides a timely policy window. The required revision of minimum quality standards can integrate autonomy and participation more explicitly into licensing and monitoring, thereby aligning organizational incentives with the national strategy and European principles for affordable, accessible, high-quality, person-centred long-term care [26, 32, 37].

Theoretical contribution

The concept of emergent institutional ageism extends analyses that locate ageism primarily in attitudes or individual decisions. It directs attention to interactions among regulation, accountability, professional practice, organizational resources, family involvement, and older people's socially constructed status as vulnerable. This framing does not label protection as inherently ageist. Instead, it identifies the conditions under which legitimate protective systems may produce age-differentiated restrictions that are normalized, cumulative, and difficult to attribute to a single actor.

The model also clarifies why reform cannot rely only on staff training or anti-ageism awareness. Individual attitudes matter, but the regulatory environment shapes what staff are required to prioritize and document. Systems change therefore requires aligned standards, inspection criteria, decision-support processes, workforce resources, and resident governance mechanisms.

Strengths and limitations

A strength of this study is its analysis of the contemporary Romanian policy architecture across multiple legal and administrative levels, including reforms introduced between 2022 and 2026. The exclusive use

of public documents makes the corpus transparent and reproducible and removes risks associated with personal records or retrospective participant data. The directed-inductive approach also distinguished broad principles from operational and evidentiary requirements, allowing a more precise assessment of implementation potential.

Several limitations are important. First, documents prescribe or enable practice but do not demonstrate what happens in residential facilities. The findings identify implementation conditions and plausible mechanisms, not the prevalence of ageism or its effects on residents. Second, the analysis was limited to national instruments and did not include local regulations, provider procedures, inspection files, contracts completed in practice, or residents' perspectives. Third, the corpus spanned documents with different legal authority and purposes, and the interpretation of regulatory density is qualitative. Fourth, Romanian legislation was undergoing transition in mid-2026; subsequent amendments to quality standards may alter the identified pattern. Finally, the concept of emergent institutional ageism requires validation through comparative facility studies, resident-led research, observation, and analysis of implementation data.

Conclusions

Romanian regulation of residential long-term care formally recognizes older people's rights, individualized needs, involvement, and preferences. However, safety, risk, documentation, and organizational accountability are more densely operationalized than supported decision-making, everyday choice, and resident influence over institutional rules. This imbalance creates a protection-autonomy paradox in which well-intentioned systems may generate conditions for benevolent institutional ageism during implementation.

Reform should not weaken safeguarding. It should make autonomy equally actionable and auditable by requiring meaningful options, communication support, proportional risk decisions, direct engagement with residents, and participation in service governance. The concept of emergent institutional ageism offers a testable framework for examining how age-related constraints arise from interactions across regulatory and organizational systems.

Abbreviations

EU: European Union; LTC: long-term care; SRQR: Standards for Reporting Qualitative Research; WHO: World Health Organization.

Declarations

Ethics approval and consent to participate

Not applicable. The study analyzed only publicly available legal, regulatory, strategic, and administrative documents. No human participants, human data, personal records, case files, interviews, or identifiable information were accessed or analyzed.

Consent for publication

Not applicable.

Availability of data and materials

All documents analyzed in this study are publicly available through the Romanian Legislative Portal. Document identifiers, titles, and web addresses are provided in Table 1 and the reference list. The analytic codebook is supplied as Supplementary File 1, and the source-linked evidence matrix containing the analytic data needed to evaluate the principal thematic claims is supplied as Supplementary File 2.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

SC conceived the study and developed the theoretical framework. SC and DZM contributed to the study design, document selection, interpretation, and manuscript development. SC drafted the manuscript. DZM critically revised the manuscript for important intellectual content. Both authors read and approved the final manuscript.

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Authors' information

SC and DZM are social work and social policy scholars with research interests in ageing, long-term care, social services, institutional vulnerability, and health equity.

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