

2013

A New Approach to an Old Problem: Defining Nursing's Role in Successful Transitions to Long-Term Residential Care

Kyleen Aldrich
University of Massachusetts Boston

Follow this and additional works at: https://scholarworks.umb.edu/honors_theses



Part of the [Geriatric Nursing Commons](#), and the [Gerontology Commons](#)

Recommended Citation

Aldrich, Kyleen, "A New Approach to an Old Problem: Defining Nursing's Role in Successful Transitions to Long-Term Residential Care" (2013). *Honors College Theses*. 6.
https://scholarworks.umb.edu/honors_theses/6

This Open Access Honors Thesis is brought to you for free and open access by ScholarWorks at UMass Boston. It has been accepted for inclusion in Honors College Theses by an authorized administrator of ScholarWorks at UMass Boston. For more information, please contact scholarworks@umb.edu.

A New Approach to an Old Problem: Defining Nursing's Role in Successful Transitions to

Long-Term Residential Care

Kyleen Aldrich

University of Massachusetts Boston

College of Nursing and Health Sciences

Submitted in partial fulfillment of the Honors Program

Abstract

A growing body of nursing research addresses the transitional period for older adults entering long-term residential care. However, gaps exist in our understanding of nursing's role in the transition process. Our aim is to examine the available evidence and develop a model of nursing strategies and interventions to ease the transition to long-term care. This model describes interventions that nurses can incorporate into everyday practice.

A literature review was conducted to examine the transitional care needs and interventions for older adults with a goal of developing a model addressing transitions to long-term care.

Most nursing studies provided descriptive information about patient experiences, nursing roles or long term care characteristics. Very few reports described intervention trials. Our proposed model includes domains of therapeutic communication techniques, developing quality therapeutic relationships, type/characteristics of the transition, empathic care, preparation and prevention, environment modification, and the personalization/individualization of care. The multiple domains in the model facilitate and support the delivery of individualized person-centered care in the long-term care setting. Proposed quality outcomes include measures of patient satisfaction, patient adjustment, quality of life (including function), and health status (clinical and physiologic measures).

Based on the literature review, the model identifies key issues and gaps in nursing care relevant to this patient population as they enter the long-term care setting. The model also provides a guide for future research, initially observational studies, and subsequent development and testing of innovative strategies to promote a successful transition. Further consideration is given to questions related to how the transition is facilitated in assisted living versus nursing

home settings, where the transition originates, unique challenges for cognitively or mobility impaired older adults experiencing residential transitions, and how successful transitions are measured (maintenance of function, control, and independence).

Keywords: older adults, long-term care, nursing interventions, patient/person-centered care, nurse-patient relationships, transition, adjustment.

A New Approach to an Old Problem: Defining Nursing's Role in Successful Transitions
to Long-term Residential Care

Introduction

One of the most difficult and challenging times in an older adult's life is the sudden or impending transition into long-term residential care. This situation is often compounded by a change in health status, the death of a spouse, and the loss of a home. This major life change is stressful for older adults, their families, and the health care teams involved. Numerous studies have been conducted on the phenomena of transition, relocation, and adjustment to long-term residential care that is focused on the older adults' experience and perspectives. However, research is lacking that focuses on what the nurses' role should be in this transition process, and how the nurse can better facilitate the transition to promote a positive adaptive experience. If the transition process and experience is guided smoothly and positively enhanced with the help of nurses, the quality of life and quality of care will be improved for older adults moving into long-term care settings.

In 2012, approximately nine million men and women over the age of 65 received long-term care and it is estimated that by 2020, 12 million older Americans will need long-term care (Medicare, 2012). The occurrence and need for older adults to enter into long-term care is increasing rapidly and in large numbers. Because of the increasing life expectancy, the presence of chronic illnesses becomes more abundant and the need for more skilled care is causing a shift from family caregivers to long-term care services. The statistics indicate that a greater percentage of the older adult population demonstrates the need for long-term care and thus they will experience a transition into receiving long-term care. It is vital for nurses to understand the process and experience of transitioning to long-term care because it is not a temporary change; it

is a transition of setting, health, and life that is permanent. Nurses are key professionals in an opportune position to function in an influential role during the transition process. However, it is likely that an open discussion and compelling guidance as to how nurses can effectively perform as facilitators of transitions into long-term care does not yet exist. Issues arising from this are the absence of education preparation for nurses in long-term care settings and that these settings most likely do not implement best care practices. There is a real need for the development of a systematic approach to identify interventions that will facilitate positive adjustment and meet older adults' individual needs and values.

Purpose

The aim of this thesis was to develop a model of nursing strategies and interventions to ease the transition of older adults entering into long-term care settings.

Methods

A literature review was completed to examine the transitional care needs and interventions for older adults entering into long-term care. A literature search was conducted to inform the proposed model.

Search strategy

Key terms were older adults, long-term care, nursing interventions, patient/person-centered care, nurse-patient relationships, transition, and adjustment.

Database

The database used was Cumulative Index to Nursing and Allied Health (CINAHL) was searched for articles published between the years 2002 to 2012. Reference lists of retrieved articles were reviewed for relevant studies and a few studies were added to this work.

Exclusions

Home care and community nursing care studies were not included because they are not formal long-term residential settings. Non-research articles were included only if they related specifically to nursing interventions that could be used to ease the transition into long-term care for older adults.

Settings

The following long-term residential care facilities were included: assisted living facilities, assisted living facilities, and nursing homes.

Process

The author reviewed abstracts of the literature search for appropriateness, excluding home and community levels of care in order to maintain a focus on long-term residential care settings. The author developed a table of evidence for comparison of the studies (Table 1). From this table, the author identified key themes, which were then used to develop an initial model. Finally, the author reviewed articles to make sure all key findings were included and revised the model accordingly. A second table was created to coincide with the organization of the final model to more clearly show the comparison and overlap between the studies (Table 2).

Findings

Studies were analyzed for similarities, differences and nursing interventions were identified that eased older adults' transitions to long term care settings. Qualitative findings of residents' views were the basis of proposed nursing interventions that may improve the transitional care experience. Twenty of the studies and articles reviewed were included in the model, yet subsequent articles were used to supplement the information included in the discussion of the model. Studies described resident experiences, nursing roles or characteristics

of long term care settings and practice. Few of the reviewed studies described specific interventions nurses could use to facilitate the transition into long-term care for older adults, yet there were none that described intervention trials. The key results, findings, and implications from the literature review were compared and compiled into similar groupings to form the main domains of the model with subsequent nursing interventions. Both qualitative data and implications for nursing interventions are used as evidence throughout this thesis, because the majority of research on this topic focuses on the older adults' perspectives and experiences, so that person-centered care interventions can be based on their responses.

Results

This model addresses key issues and gaps in nursing care relevant to the older adult population as they enter long-term care settings. The purpose of the model is to provide strategies and interventions that nurses can incorporate into everyday practice.

Overview of the Model

The main theme of this model is the delivery of individualized person-centered care in long-term care settings (Figure 1). Seven domains of nursing care were identified to promote person-centered care to ease the transition into long-term care. These domains include (1) therapeutic communication techniques, (2) developing quality therapeutic relationships, (3) type/characteristics of the transition, (4) empathic care, (5) preparation and prevention, (6) environment modification, and (7) the personalization/individualization of care. There was significant overlap among the articles in regards to recurring key themes and domains of the model, as evidenced by Table 2. The domains that make up the model facilitate the overarching theme of person-centered care. The strong interrelationships among the domains portray the importance of providing person-centered care within the current institutional constraints.

Preparation and prevention is a key issue addressed most frequently in the studies. Empathic care and therapeutic communication were issues referred to the least in the literature. This could possibly be attributed to the multifaceted definition of empathic care and/or the assumption that therapeutic communication is often not considered a complex skill requiring further analysis in relation to transitions to long-term care.

Person-Centered Care. Person-centered care is at the center of the model serving as the foundational concept upon which care is based. All the other domains include key principles relating to person-centered care. The purpose of the model is to guide nurses in providing quality care to older adults that will concurrently improve quality of life during a difficult life change. The key messages and implications for nursing interventions were combined and organized to form the model of nursing interventions that nurses could use to ease older adults' transition to living in a long-term residential care setting. The main question that the model addresses is how can person-centered care be achieved within the current institutional constraints? One study described nursing staffs' perceptions of the older adult's transition experience (Wiersma, 2010). The nurses in the study stated that they were aware and cognizant of issues contributing to relatively little emotional care being provided, but felt that they were powerless and unable to change the way their work is done due to institutional time constraints, staffing shortages, and task-focused work (Wiersma, 2010). However, are there ways that nurses can efficiently incorporate empathic person-centered care in their everyday work routines without increasing the burden of a heavy workload?

The Institute on Medicine (IOM) defines patient-centered care as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (Institute on Medicine, 2001, p. 3). Patient-

centered care is often used interchangeably with person-centered care, but are they the same concept? Starfield (2011) states,

In contrast to patient-centered care...person-focused care is based on accumulated knowledge of people, which provides the basis for better recognition of health problems and needs over time and facilitates appropriate care for these needs in the context of other needs. That is, it specifically focuses on the whole person (p. 63).

Person-centered care was the term chosen to represent the key concept in the model because it implies the most individual and holistic approach to care and used in long-term and residential settings.

Empathic Care. Empathic care is one of the main domains of the person-centered care model. Eleven of the reviewed articles addressed empathic care and most of them supported the incorporation of empathic care into physical care. Social/emotional support is particularly important during times of crisis and stress. The role of a nurse is to care not only physically for those they care for, but emotionally as well. In order to understand how nurses can ease the transition into long-term care for older adults, we must first understand how nurses themselves perceive the experience (Wiersma, 2010).

Patterson (1995) described older people's views of socially supportive actions as they adjusted to life in a nursing home. Older adults most frequently identified emotional support as important to facilitating the transition. Specifically, emotionally supportive were actions by staff that expressed love/concern/respect and were pleasant/kind/patient (Patterson, 1995). Older adults reported needing emotional support most after initially moving into long-term care setting and later when they are finally settled and want to make meaningful relationships. Older adults identified nursing staff as the group providing both supportive and/or non-supportive behaviors, whereas, their family members primarily provided material/financial help (Patterson, 1995). This

study highlights the importance of nurses in providing emotional support and their role as essential and one that is most meaningful to the resident. There were many descriptions in this study stating that empathetic care often occurred when nurses provided practical assistance or physical care (Patterson, 1995). However, practical assistance provided by nurses without emotional support was often perceived as unhelpful (Patterson, 1995). This is likely because physical care in the absence of emotional care is depersonalized care, which is the opposite of person-centered care. This study is a useful contribution for nurses who may use this data as a means for incorporating emotional support in their physical care as they progressively become the primary support for some residents as they move away from their family (Patterson, 1995). Nurses should adopt an approach of conversing with residents while simultaneously providing physical care. This is a simple way to multi-task and provides person-centered care simultaneously. It is such a simple intervention to incorporate into an already established routine that greatly improves resident satisfaction and quality of life.

Respect and dignity is also a very important aspect of providing empathic care. Long Term Care Facility (LTCF) nursing staff holds a key role in preserving older adults' dignity and conveying respect (Coughlan & Ward, 2005). An important and common area of care that is strongly linked to a sense of dignity is the issue related to toileting. However, inadequate staffing when residents are waiting for staff to use the toilet can cause problems. Residents are sometimes incontinent if nurses are not able to assist them in a timely matter, which leads older people to feel embarrassed and degraded (Wiersma, 2010). It has been found that the lack of attention to helping residents to the bathroom actually exacerbates the condition of incontinence and can lead to feelings of dependence (Mather & Bakas, 2002). This pattern of ignoring residents' calls to use the toilet can lead to the resident being labeled as incontinent and can lead

to the resident conforming to that definition by resorting to wearing incontinence products, ultimately resulting in a decreased sense of personhood (Sacco-Peterson & Borell, 2004). This incontinence and dependence can be a result of nurses attempting to meet the expectations and demands of the job in the allotted amount of time during their shift (Sacco-Peterson & Borell, 2004). It seems that with an increased work load, nurses tend to cut corners; but the corners that get cut are what is considered to be 'extra' work such as these tasks that involve conveying dignity and respect towards older adults while performing care.

Providing empathic care requires a change made in the focus of care. One can ask the question, how do priorities change from task-oriented to other needs when an older adult transitions into long-term care? One author refers to the process of transitioning to long-term care as a breakdown in which there is a shift in attention to what is truly meaningful to the resident (Heidegger, 1962). Due to the longevity and intimacy of long-term care, social interaction and social support assumes an even greater role for older adults (Patterson, 1995). It is crucial to provide empathic care to older adults who may now assume a more dependent role because it is likely to influence their participation in their care, as well as acceptance of this type of support (Patterson, 1995).

Promoting personal control and decision making is part of providing empathic care to older adults because it preserves autonomy and independence; two aspects of life that also seem lost when moving into long-term care. There are two main issues involving control and decision-making; decisions to move into a LTCF and those decisions made after the move takes place. It has been found that the ability to exercise control over aspects of daily life is especially significant for residents admitted into a LTCF involuntarily (Kao et al., 2004). However, it is essential for nurses to provide opportunities for choice and decision-making for all residents

because by promoting control and decision making in regards to older adults' individual needs and preferences, nurses can effectively minimize the negative effects caused by the transition (Fraher & Coffey, 2011). After residents have relocated, nurses should allow older adults to make choices about their care and to make decisions about things that are meaningful to them and will not affect care negatively. To accomplish this, "staff should establish trust and convey respect" and give residents choices in areas such as "which activities to attend, food preferences, and the amount of staff-resident-family interaction they desire" (Iwasiw et al., 1996, p. 387). If nurses allow older adults control and decision-making, they will empower residents, promote their independence, and help to instill confidence. Empowering residents to feel continuing control of their daily lives during the transition to long-term care is part of providing empathic care because it maintains an older adult's sense of humanity.

In long-term care, there is a strong focus on preserving safety and minimizing risks. For example, a nurse explained in one study that she believed she was protecting the resident by not wanting the patient to walk because he was at risk for falling (Wiersma, 2010). However, this nurse did not realize that coercing him to be wheelchair bound could lead to his loss of independence and to an ultimately worsening cognition, depression, and giving up on walking. Nurses tend to focus on providing safe care as a priority over providing emotional care (Wiersma, 2010). However, this focus on physical care and safety has unforeseen consequences on health and cognition although the intentions are just. It seems there is a connection between the loss of independence and autonomy and declining of functionality. Sometimes the answer is to provide assistance with walking, which would require more staff time.

In order to care for older adults in an empathic manner, nurses must appreciate the older adults' loss and allow them time to grieve adjustment to occur. One way to accomplish this is to

allow residents to express feelings regarding their experience (Iwasiw et al., 1996). The following statement attempts to grasp the experience from an older adult's perspective:

Residents have not only left a home but a part of who they are. They are grieving their loss, each in their own way and in their own time. There is an initial period of almost disbelief and chaos when new residents enter the unfamiliar and are unknown. Allowing residents to grieve for their 'lost' home may be an appropriate first step. The strategy of listening to and respecting the memories of what was begins the process of transition (Heliker & Scholler-Jaquish, 2006, p. 41).

Bridges' (1980) model of the conceptualization of the transition process is often used to interpret how older adults' experience the transition. In this model, there are three phases said to make up the transition process: 1) ending, 2) neutral zone, and 3) new beginning. Using this model, Young (1990) found that the most influential time to learn about the resident's experience was during the first phase, in which the nurse could seek to explore and understand the older adult's experience and perception of the transition, and provide needed emotional support in recognition of their losses, including precipitating events, loss of a spouse, health crisis, etc. These details "can help staff understand the extent of life change being experienced by the relocatee" (Young, 1990, p. 81). When leaving one's residence and transitioning into long-term care, older adults can experience multiple losses. If an older adult is grieving a specific loss like a death of loved one or a home, it deserves the same kind of attention and respect as is determined by the individual's perception. If an event is perceived to be a great loss by the individual, then that is how it should be acknowledged and treated by those caring for that individual.

The literature supports the domain of empathic care as it relates to person-centered care in that it individualizes care and instills a humane approach to care being provided. The literature seems to collectively advocate for the combination or inclusion of empathic care within physical

care, in order to allay the focus from the physical body to the actual needs and desires of the older adult receiving the care. Nurses' efforts to minimize the loss of an older adult's autonomy and dignity are essential to providing empathic care.

Environmental Modification. Environmental modification is an integral part of making an older adult adjust well while becoming a new resident in a LCTF. The strategy of modifying the environment was discussed in eight of the articles included in the literature search. The admission to a LCTF was described as feeling similar to "becoming homeless", where one has to enter an unfamiliar place, get settled, and create a new place (Heliker & Scholler-Jaquish, 2006, p. 37). The authors express the meaning of home as where one maintains identity and independence related to a sense of "self-meaning, purpose, authenticity, continuity, and cultural identity" (p. 37). With home representing multiple meanings, the loss of one's home can be very closely linked to losses of familiarity, comfort, and habit, as well as the loss of an identity (Heliker & Scholler-Jaquish, 2006). Therefore, nurses need to "be present" during this troubling time where the meanings of identity are challenged (p. 40). Knowing this information, what then is the role of the nursing staff in modifying the environment to effectively ease an older adult's transition into long-term care? It was noted in one study that nursing staff was often in such a hurry to accomplish healthcare related tasks, that they did not acknowledge difference between the facility as more than a workplace for them, where as it s the residents' home (Coughlan & Ward, 2005).

The first feature that comes to mind when thinking about the environment is the physical surrounding itself. The literature supported the idea that providing familiarity through the process of environmental modification has the ability to significantly ease the transition for older adults moving into a foreign place. This was one area of person-centered care that older adults

found very important in multiple studies. Individualizing a person's environment seems to be a way to provide person-centered care.

Young (1990) found that possessions that are considered to be important to residents can make a new environment more familiar and can be a source of continuity in a time of change. It is a common understanding that healthcare facilities have stringent rules and regulations that must be followed to ensure patient safety, but Young (1990) argues that institutional constraints regarding personal possessions of residents should be reevaluated in light of the significance of the belongings to the well-being and self-esteem of residents and that when possible, accommodations should be made to include personal touches in a resident's environment. Providing for familiar objects to be present has been found to bring comfort to residents, and may also simultaneously alleviate confusion that is brought on by the abrupt change in surroundings (Walker et al., 2007). Another approach suggested by Wilson and Davies (2009) was that by listening to stories told by families or residents, nurses can spark conversations using photos or other personal items in order to recognize details of personal care that are significant to each resident.

There are other aspects of the environment that also need modifying and monitoring that are not related to the physical objects and appearance of the room. There are many ways an individual can relate and interact with their environment. Kao et al. (2004) emphasize the need that assessment of the environment is continuous, like any other nursing assessment of the patient, and that there is a kind of interrelationship between resident and environment that exists. The change in surroundings can be what is most upsetting to the older adult at the time of the transition and their reactions must be evaluated and cared for in whatever manner assists them most in the adjustment process. But what about the social environment? Many health care

providers may not consider the loss of a spouse as having an effect on the way an older adult perceives their environment. Not having a loved one present that once was a significant aspect of an older adult's everyday life is a significant and traumatic change, in addition to the move to a new and strange environment. This example signifies the importance of assessing the environment in a variety of ways.

One way to indirectly modify the environment is the effective use of routine management. Residents have to be woken up early for morning care, are to eat when it is time to be in the dining room, and follow prescribed care routines they don't have a part in directing. What defines life in the facility, defines the life of the resident (Wiersma, 2010). Residents lose their life routines to which they were accustomed and are then dictated by the rules and regulations of the routines in the facility. In one study, nurses described using work routines as a means of learning about the resident, while becoming familiar with personal routines of individual residents simultaneously (Wilson & Davies, 2009). In this way, knowing preferences of individual residents helped nurses anticipate what each resident might need and when. The quality of relationships was not a main focus for nurses in this study. Instead they focused on the practicalities of the tasks at hand and the resident's safety, making it appear as if nurses were not focused on the residents as individuals.

While focusing on the task made work easier for staff, it resulted in a pragmatic relationship, however the use of care routines has also been found to help personalize care. Wilson and Davies (2009) found that, the process of developing shared understandings between staff and residents included the planning and organization of care routines to take into account the needs of all involved (the staff, resident, and family). Care routines were organized in ways that acknowledged the personal priorities of each resident in order to ensure staff was in the right

place close to the right time when specific residents would need support (Wilson & Davies, 2009). A way for nurses to ease residents into a new routine that is still personalized is to offer alternatives and explanations as to why routines are organized the way they are in order to achieve effective time management to meet multiple residents' needs (Wilson & Davies, 2009). Routines provide structure and organization, however maintaining personal routines can lead to individualized care. This is especially relevant to the importance of timing and caring for resident's needs for personal hygiene, eating, and toileting (Wilson & Davies, 2009).

The relocation to a nursing home involves a compromise in the amount and type of privacy an older adult receives. An important question for nurses to ask themselves is: how can an older adult's privacy be respected within a new confined environment such as a LTCF? Proximity to others can be a complication for many residents in relation to issues such as visiting, toileting, maintaining one's private business, and unintentionally observing the plight of other residents (Fraher & Coffey, 2011). Adjusting to a small space and lack of privacy is distressing for many older adults, therefore it is important for the nurse to always knock on residents' doors and introduce themselves each time they enter a patient's room and not simply walk in without a word and begin providing hands-on care (Wilson, 1997). Perhaps the most important concern relevant to privacy issues is of the physical body. Wiersma (2010) found that privacy was an aspect of residents feeling like they were being regarded as a body and being seen as only a physical object. This study found that any notion of privacy or modesty were compromised after moving into a LCTF because staff provide such intimate care, causing residents to adjust to their bodies becoming "public property" (p. 430). This can be very upsetting, and even dehumanizing to individuals who highly value the privacy of their bodies, and who are also dealing with the inability to take care of their own bodily needs and who must

accept the aid of strangers. Different levels of privacy are needed for each resident. Interacting with residents during personal care is important. It is always essential to ask permission when having to expose someone's body, to allow for choice and preferences in intimate care, and to convey respect no matter how long a nurse has cared for a certain patient. Common courtesy should apply in all situations involving physical care.

There are new models of care emerging that seek to specifically address the environment of institutional facilities, referred to as the "culture change movement" that aim to improve the quality of care and quality of life for people residing in long-term care environments. Bowers and Nolet provided quantitative data supporting the Greenhouse model of care (Bowers & Nolet, 2011). Their study was based on care staff perspectives on the Green House model, which aims to "de-institutionalize" nursing homes. This is accomplished by creating smaller homes and providing person-centered care. The study results supported the idea that when nursing staff are empowered, they are more satisfied with their work, and as a product of this, quality of care and quality of life will improve for residents (Bowers & Nolet, 2011). Another LTCF called Evergreen is another example that creates an environment less like a nursing home and more like a home-like setting (Baldauf, 2010). These "progressive homes" are built in the design of community households or small neighborhoods with less rigid schedules, where dignity and individuality are priorities. There are a decreased number of residents per nurse so that more individualized care can be provided in a home-like setting. This model attempts to foster individuality with personalization, encourage socialization and activities, provide continuity of caregivers, and find a balance within institutional constraints to honor resident's choices (Baldauf, 2010). The Aging in place (AIP) model also supports the premise that older adults should remain in the environment of their choice, in order to age well and sustain a high quality

of life, such as providing care to older adults residing in specially designed senior apartments, senior congregate housing, their own homes, or their communities (Rantz et al., 2008). In this way, older adults are enabled and encouraged to stay in their own homes with the goal of maximizing independence. It also would prevent the need to move from one level of care to another as health care needs change, and decrease the number of transitions one would have to experience (Rantz et al., 2008).

Preparation and Prevention. The concept discussed and emphasized most often throughout the literature was preparation before the transition and prevention of factors leading to a poor transition. Fourteen of the articles mentioned preparation and prevention. Proper preparation for the transition into long-term care can result in prevention of adverse complications and promote a more positive and successful experience of the transition. Young (1990) states that, “through adequate preparation, staff can become more sensitized to the needs of the older person who is faced with a major life change” (p. 81).

One of the key aspects mentioned in the literature in regards to preparation and prevention is a comprehensive assessment of the individual in order to identify risks for a poor transition. The question is: how and when should nurses perform this assessment? To ensure a successful transition, there must be some point of contact in the interim of relocation. If prevention is not possible, it is important to assess and intervene as early as possible after the transition has taken place (Oleson & Shadick, 1993). Issues affecting all aspects of the individual can arise quickly and persist after admission. The importance of a psychosocial assessment is considered to be particularly significant (Walker et al., 2007). Achterberg et al. (2006) also highlighted the importance of a multidisciplinary approach for the overall assessment and management of nursing home residents in their study on the presence of depressive symptoms in

newly admitted nursing home residents. The authors highlighted the importance of conducting psychological and social assessments in addition to a comprehensive medical assessment in order to fully achieve quality of life for nursing home residents (Achterberg et al., 2006).

Fraher and Coffey (2011) proclaim that, a pre-admission individual assessment should be completed to enable care providers to address key factors in a person's life, including aspects of function, health, social support, service use, and quality of life in order to inform the receiving care facility of the person's needs and preferences in advance, providing a more person-centered approach to the admission process. Wiersma (2010) states that the admission process is often viewed as time consuming by nurses due to additional paperwork, and often leads to labeling and making assumptions about new residents. Yet, individualizing the assessment process results in person-centered care than enables more person-specific interventions to promote a better transition. The reason for the importance of a comprehensive assessment before the older adult makes the transition into long-term care is made clear by Rossen (2007), who proclaims that,

With the increasing numbers of older adults moving to ILCs [independent living communities], there is a need for healthcare professionals to assess the readiness of older adults to go through the situational transition of a move to an ILC, so that those who are at risk for negative outcomes and potentially costly healthcare use can be identified and interventions developed to prevent these negative outcomes” (p. 293).

In addition to identifying risk for a poor transition, a comprehensive assessment can also enable the nurse to determine the *readiness* of an older adult to make the transition, as mentioned by Rossen (2007). This degree of readiness will have a great effect on the outcomes of the transition and if it was successful or not. Parameters that were defined by Rossen (2007) for assessing older people's readiness to move to include: choice of relocation, preparation for the move, congruence between the ILC and the older person's expectations, existence of a confidant,

and openness to forming new relationships. In order to accomplish a complete assessment of the factors involved in the readiness for transition, Rossen (2007) developed two tools that can be used to assess the individual's risks for negative relocation outcomes, including a set of questions to be used in an interview.

The assessment is not comprehensive if it is not done sequentially, meaning before, during, and after the transition. After conducting a complete assessment, how can one determine if someone has transitioned successfully? Rossen (2007) described three major concepts in their transition model:

- 1) Universal properties: characteristics of the process of movement from one state to another such as changes in identity, roles, relationships, abilities, and patterns of behavior;
- 2) Transition conditions: personal and environmental factors that influence the transition, such as physical and emotional well-being as well as person-environment interactions;
- 3) Indicators of a healthy transition: factors that indicate the quality of the transition outcome, such as satisfaction with the new home and perceived quality of life (p. 293).

The first two concepts involve an efficient and comprehensive assessment, while the third concept is a way to evaluate the outcomes after the transition, which can then be used to decide which interventions the older adult needs to successfully adapt. In order to 'measure' the adjustment of the older adult after the transition, Lee (2010) used the Nursing Home Adjustment Scale. For the purposes of the study, it was an instrument specifically designed for nursing homes and the specific transition experience of moving into long-term care so that factors relating directly to adjustment could be identified. Lee (2010) studied how to make nursing staff more aware of the variables that influence a resident's adjustment, so they may be more likely to assist residents in making a better transition. Measurement of adjustment included the following

factors: decision making, preconception of nursing homes, preparation period, and prior life satisfaction (Lee, 2010). In measuring adjustment factors, nursing home staff should consider the characteristics of older adults and the events surrounding the relocation in order to facilitate tailoring care to each individual during the relocation adjustment period (Lee, 2010). Although factors related directly to adjustment were identified by older adults responding to the questionnaire, it was not evident whether this scale used was helpful for nurses. A study/intervention trial investigating whether this would be a useful practice for nurses would be a beneficial addition to this study's findings.

According to the literature, in order to prepare for the transition, well-organized coordination of care across settings must take place. Effective communication during patient handoffs and along care trajectories is essential for acquiring pertinent information about the resident and has been found to significantly reduce the stress of the transition process (Young, 1990). Lee (2010) proposes that, a "transitional care plan" be used to facilitate the transition before admission takes place (p. 962). Nurses are in a prime position to be a leader in the process of facilitating the coordination of care of older adults as they transition into long-term care.

Although nurses may be main participants who can facilitate care of the older adult across settings, there must be more members of the healthcare team involved. All healthcare providers of different specialties that will be caring for the older adult should be involved in facilitating the transition process. Heliker and Scholler-Jaquish (2006) propose the idea of a transitional care team that will guide the transition process for newly admitted residents in the nursing home. They recommended the team include the resident, family members, nurses and nurse's aides, physicians, activities director, social worker, dietician, and chaplain. Kao et al.'s study (2004) focuses on care coordination and emphasizes the role of the interdisciplinary team

in providing seamless transitions to nursing home care. In order to accomplish this seamless transition and proficiently coordinate care across settings, the nursing home staff must communicate with the team from the discharging facility and maintain ongoing care coordination between care settings throughout the older adult's care trajectory (Kao et al., 2004). Transitions to LTCFs are not temporary, however older adults are often temporarily relocated between other levels of the healthcare system. As they move through the healthcare system, they must readjust each time to new situations, new routines, new staff and new environments. Therefore, nurses must pay close attention to the way in which older adults' progress through the phases of transition, because it is not a "linear" process (p. 16). Ensuring effective communication before the transition allows for the resident and their family members to make informed and controlled decisions (Kao et al., 2004). And like all assessments of the older adult throughout the transition process, care coordination and communication between facilities and caregivers must continue after the transition has taken place (Kao et al., 2004).

While focusing on coordinating the care of the older adult, the individual's needs should not be forgotten in this process. The literature supports preparing for admission by introducing and orienting the older adult and their families to the facilities in advance, in order to effectively lessen the negative effects of the drastic change in environment and way of life (Kao et al., 2004 & Bauer, 2006). For example, older adults and their family members could come view the facility before moving in and perhaps eat a meal in the dining area to progressively become more comfortable and familiar with the environment before the older adult moves in. This way, nurses are also able to meet with and become familiar with older adults and their families members beforehand, which can facilitate the establishment of future plans and mutual goals early in the process (Kao et al., 2004).

Multiple studies also found providing appropriate and an adequate amount of information to the resident by continuously keeping the resident informed of what to expect upon transitioning to long-term care to be of great importance during the preparation period (Young, 1990; Iwasiw et al., 1996). Lee (2010) proclaims that, “if older people were provided with more information about nursing homes through publicity or visits prior to admission, their negative preconception about nursing homes might be dispelled, positively affecting subsequent admission” (p. 962-963). This information is vital, for it provides older adults and their families’ adequate time and information for making decisions and choices (Fraher & Coffey, 2011).

Therapeutic Communication Techniques. Therapeutic communication is one fundamental aspect of nursing care that is often underappreciated or overlooked. Multiple aspects of communication are discussed within seven of the reviewed articles/studies. Although seemingly simple, it seems that nurses often experience significant difficulty in using therapeutic communication with residents, often because they are so focused on the task-based nature of their work. In one study, nursing staff was found by residents to often not be involved in conversation or small talk with residents because they were too busy charting or talking amongst themselves (Heliker & Scholler-Jaquish, 2006). Ellis (2010) concluded that, “nurses require improved communication strategies (based on the concepts of transition) that will support residents and their relatives during the admission phase” so that the older adult experiences a positive psychological transition to long-term care (p. 1159).

A way in which nurses can therapeutically communicate with residents, while simultaneously learning about the resident is by sharing stories. This also facilitates the formation of a strong relationship between resident and staff (Lee, 2010). This also applies to

communicating with residents' families, who can convey important information about the older adult to the nursing staff in order to enhance individualized person-centered care.

The way one approaches another in communication is also influential on the nature and tone the conversation will assume. An interesting finding was that nurses' previous experiences with older adults can strongly influence their approach and attitude towards other older adults, even those they have never cared for before (Ellis, 2010). This information provides evidence supporting the importance of personal introspection regarding one's previous experiences and the possible effect it can have on one's approach to care. If previous experiences can be used to extract effective communication strategies that worked well with other residents, then those experiences may be helpful when approaching another. However, nurses should make sure to appreciate the uniqueness and individuality of older adults when reflecting on their previous experiences, to ensure that assumptions or incorrect associations are not made. When nurses therapeutically communicate with residents and their families, they are able to reach a mutual understanding amongst all of them of what it means to transition to long-term care (Ellis, 2010).

When a nurse communicates with an older adult while simultaneously providing care, common courtesy and respect should be evident in the nurse's dialogue with the older adult. In one study, residents reported that they desired explanations of what nursing staff were doing and why when providing care (Patterson, 1995). Therefore it is always important for nurses to explain who they are, what they are doing, and why when they enter a resident's room to perform a task. Nursing staff needs to answer any questions the older adult may have concerning their care. Keeping an open dialogue keeps the resident informed and involved with their own care, promotes mutual understanding, and sets the foundation for a meaningful therapeutic relationship (Patterson, 1995). Another important effective communication strategy with older

adults is for nursing staff to use slow-paced speech, as well as take their time with tasks, so as to not make it seem like the nurse is rushing off to another resident (Patterson, 1995). If nurses model these communication techniques, nurses' aides may be more likely to engage with patients in the same manner as well.

Therapeutic communication with older adults in the long-term care environment should also take the circumstances of the conversation into consideration, such as the time and place. Patterson (1995) provides many useful communication techniques nurses can use in their care. Timing conversations during less hectic times and in private (not during meal times or activities) is essential to gaining trust and preserving the dignity of the individual. It will also ensure that the resident is able to concentrate and fully focus on the content of the conversation, thus, making it more meaningful. The nurse should make sure to use patience and allow sufficient time for them to respond. A relaxed and supportive disposition is also therapeutic (Patterson, 1995). However, therapeutic communication should be tailored to the individual abilities of older adults. It is essential that nursing staff remember the individuality of each older adult and realize that each resident exhibits different functional abilities in consideration of the changes inherent in normal ageing such as hearing loss (Patterson, 1995).

Attentive and active listening is often just as important as conversing in the skill of therapeutic communication. It has been found in a study by Coughlan and Ward (2005) that staff was not consistently listening and responding to residents' concerns. By encouraging the older adult to talk while the nurse listens, nurses can learn valuable information about residents' lives (Young, 1990). It has been found that immediately after the transition takes place, the more helpful approach might be for nurses to provide a warm and caring presence, and make themselves available to listen and give support, instead of trying to push the older adult into

conversation (Young, 1990). Young (1990) states that, “what might be interpreted as disengagement and poor adjustment during this phase could in reality be an important time of personal healing and reconstruction” (p. 81).

It has been found that promoting positivity in therapeutic communication has the potential to positively impact the resident’s perspective of the transition experience (Lee, 2010). Ellis (2010) suggests that,

Nurses should have discussions about the new living environment with residents and relatives and identify the advantages as well as disadvantages. This can give residents and their relatives opportunities to talk through the transition stages and pathways available to them and to offer opportunities for both residents and relatives to look forward to each week (p. 1165).

However, Ellis (2010) also states that, “an important nursing role is to invalidate a resident’s negative anticipations of what is happening and going to happen to them...and help residents and relatives to reconstrue the new environment by developing more positive anticipations of the new situation” (p. 1165). The author believes that if residents are permitted to hold on to negative conceptions of the nursing home, they are more likely to undergo stress (Ellis, 2010). However, it would be more therapeutic to appreciate and acknowledge a resident’s feelings and emotions, rather than invalidate a resident’s perspective of the transition experience. Nurses can achieve this by their approach to care and the way in which they communicate (Ellis, 2010). It seems evident that older adults are sensitive to the attitudes and perceptions conveyed by the nursing staff. Therefore, focusing on the negative aspects of the transition to the LTCF inhibits the ability to make a positive adjustment, or assist with the transition (Ellis, 2010). Nurses should maintain a positive outlook when communicating with residents while simultaneously exhibiting empathy related to the older adult’s perceived losses.

Personalization/Individualization of Care. In order to provide person-centered care, nurses must know each older adult as an individual so they may personalize his/her care. Nurses can accomplish this by getting to know the resident in a variety of ways. One possible way is by learning about the resident's past experiences that are important to them.

Ellis (2010) uses the Theory of Personal Constructs (an approach that identifies individuality of experiences) in order to make sense of challenges faced by residents and their relatives. Ellis (2010) explored the psychological transition that takes place concurrently during the physical relocation. Through acknowledging that all older adults and their families will experience and perceive the transition in unique ways, Ellis (2010) believes that nurses can make a profound difference in how the transition is experienced. Therefore, "each resident, relative and nurse is free to construct their own uniquely different version of the reality of the caring environment, and each construction is real for that individual" (p. 1167).

In order for the nurse to understand how each older adult perceives his/her unique transition experience, the nurse must listen to their stories. Young (1990) proposes that each older adult has "meaning" associated with his/her individual transition experience and that this experience is strongly influenced by the preceding events that led to the move, as well as the preconceived notions the individual has (p. 78). This concept is very closely linked to the losses an older adult may have experienced as a result of the transition. The circumstances leading up to the transition and the reasons for the relocation can be assessed to predict how well one might cope and transition into the long-term care setting.

The stories older adults tell may not seem relevant to the care they need, but it is important to discover what is considered important to each individual, and tailor care to address those aspects of life considered most essential. A study by Coughlan and Ward (2005) explored

residents' perspectives around their experience of the transition, quality of care, and their own unique interpretation of what was meaningful to them. It was found that what the residents spoke of as being important did not include any of the measurements typically recorded in health-related outcome measures such as the minimum data set, but quality of care was related to socio-psychological issues (Coughlan & Ward, 2005). Residents considered "quality of care" to be better defined as "quality of life" "that they understand 'quality of care' to be better defined as 'quality of life', and that what supported this notion most was the relationships formed between staff and the residents (p. 55). The impact that meaningful nurse-resident relationships can have on the quality of life and thus the quality of care for older adults in long-term care is a common finding among the literature.

Another study with a similar goal of acknowledging and understanding resident's perspectives and priorities was conducted by Heliker and Scholler-Jaquish (2006). This study "emphasized the significance of listening to the spoken and unspoken words of individuals whose voices and perspectives are rarely acknowledged but who must be heard to improve their care and quality of life" (p. 34). The authors believe that it is important for nursing staff and residents to come to know one another well, in order to find and share common bonds. This requires nursing staff to share information about themselves, in order to establish trust (Heliker & Scholler-Jaquish, 2006). Allowing the stories of residents to be heard would enable nursing staff to understand older adults' experiences of the transition, thus laying the foundation for individualized intervention strategies and care that is meaningful (Heliker & Scholler-Jaquish, 2006). However, it is the responsibility of the nurse to facilitate this exchange in which a trusting relationship can form. Heliker and Jaquish (2006) state that, "the challenge for nursing home staff is to create situations, a clearing for sharing stories and lived experiences, that facilitate the

co-creation (both staff and resident) of new meanings and places” (p. 41). Listening and sharing stories with residents is often seen as something that is not necessary to providing care, but is a useful and meaningful strategy to ensure and improve the individualization and personalization of care.

A method more common to nurses that will assist nursing staff in getting to know the residents is observing and assessing the individual in order to establish a baseline of health status, character, cognition, etc. for comparison. Knowing the resident establishes a baseline and enables the nurse to pick up on deviations in the state of residents and enables timely intervention (Wilson & Davies, 2009). Oleson and Shadick (1993) suggest that nurses assess “background and personal factors, event-related factors, and physical and social environmental factors to provide data that will help nurses understand how a particular individual may respond to entering the nursing home” (p. 481-482). This should include individual values and beliefs. In addition, nurses should assess the older adult’s past responses to life transitions and crises before planning to intervene (Oleson & Shadick, 1993). Knowing how an individual coped during previous experiences could inform the nurse of coping strategies to promote for that particular resident, while avoiding pressuring the resident to use other methods (Oleson & Shadick, 1993).

Individualizing care for an older adult includes promoting personal identity to make the older adult feel like they are more than just one of many patients. Residents often find that the transition prompts them to reestablish themselves and adopt a new identity, however it is often one of increased dependence. A study by Coughlan and Ward (2005) found that, “many residents felt the sharp distinction between their previously independent lives, whereas, now, they reported that they often felt they are merely a list of tasks for staff to attend to (p. 52). A loss of a sense of personhood, value, and dignity occurred for most residents. Residents exclaimed that they often

felt like interventions themselves (Coughlan & Ward, 2005). The nature of conventional nursing work makes the personalization and individualization of care, and even the promotion of personal identity, a challenge. A study by Weirisma (2010) focused on residents' perspectives found that many older adults felt that they were defined by their bodies due to the loss of independence associated with the transition to the LTCF, and that nursing staffs' constant focus on the physical body strengthened this feeling of depersonalization. With the pressure to complete the physical care necessary for residents in LTCF, nursing staff may not always realize how rough they are being while rolling, moving, and bathing people without embellishing a touch of humanity and compassion. Treating and caring for residents as individuals and promoting personal identity can ensure that one's humanity is maintained. In addition, simple interventions can also be used to instill personal touches in care.

Develop Quality Therapeutic Relationships. The evidence supporting the positive effects of meaningful therapeutic relationships between resident and nursing staff is found in eleven studies of the literature review. Admission into long-term care (LTC) can potentiate the loss and proximity of family and friends, making the newly formed close relationships with staff that much more important for older adults. McGilton and Boscart (2007) state that, "the relationship between a resident and care provider in LTC environments is unique because of its longevity and its institutionalized character" (p. 2150). These relationships have an impact on both the resident's quality of life and care provider's job satisfaction, and have been found to foster residents' ability to adjust (Lee, 2010). Close relationships are difficult to form when care is conducted in a formal environment, yet there are ways to make care more informal and facilitate the formation of meaningful relationships. McGilton and Boscart (2007) examined the different perceptions of residents, staff, and family with regard to close care provider-resident

relationships in long-term care. Nurse-resident relationships were found to be crucial to the quality of life of the residents and have the ability to enhance resident care. (McGilton & Boscart, 2007). However, the question that remains is, how are these relationships defined and measured?

In McGilton and Boscart's study (2007), all groups defined nurse-resident relationships differently but agreed that there is a desire for meaningful relationships, however, residents reported inadequate nurse staffing and time necessary to establish close relationships with staff. This sentiment is reflected in other studies as well by residents, families, and nurses alike. Time constraints of work act as a barrier that hinders the creation of meaningful connections and relationships. The perceived formality of the institutional environment also impedes making a connection (McGilton & Boscart, 2007). If these barriers seem insurmountable to nurses and their residents, what strategies can nurses implement in their practice to surmount these barriers and make their work more personalized and informal? How can they manage to construct meaningful nurses-resident relationships within the time constraints?

As for the nurses' perspective, "care providers identified knowing the resident as being essential to understanding resident's needs and emotions so that they could deliver care that met those needs" (McGilton & Boscart, 2007, p. 2157). They described feeling connected as knowing what residents would like or knowing how residents act, and that these relationships should be reciprocal, like in a partnership (McGilton & Boscart, 2007). Residents described wanting a relationship with a close care provider who has their best interests at heart, takes initiatives/doing extra things without being asked, is dependable and someone who listens to them, and who jokes and laughs with the resident (McGilton & Boscart, 2007). These are common attributes of informal relationships and are considered the most important

characteristics of a meaningful relationship according to older adults. However, in order to effectively establish a meaningful relationship with a resident, the nurse must first “know the resident” (McGilton & Boscart, 2007, p. 2152). Factors that care providers felt enabled them to be in close relationships with residents were conversing about various topics, sharing stories from the resident’s past and those of private affairs, but they often felt that they had no time left to listen to what residents want to tell them (McGilton & Boscart, 2007). Residents reported that they were interested in becoming involved in a close relationship, but a few mentioned that the ultimate decision about proceeding was left up to the care provider. This means that the nurse had to take the initiative in forming close ties with residents (McGilton & Boscart, 2007). This study prompts the question: what should relationships between care providers and residents look like? McGilton and Boscart (2007) propose that “it may be that the needs of the residents that should dictate the type of relationship that is required between the two – facilitated by knowing the resident/tailoring to the individual – care providers will then be called upon to become aware of the meaning of the relationship for each of the residents they care for” (p. 2155).

Wilson and Davies (2009) sought to discover how relationships between care providers and older adults in LTC are initiated, maintained, and defined. This study found that the methods of care determined which type of relationship was formed and revolved around how staff focused their care; on the task, the resident, or on the relationship. Three main types of relationships were found to exist in the long-term care environment:

- 1) Pragmatic: focused on the practical nature of caring, communication revolving around task at hand – developed through an individualized task-centered approach to care which included getting the job done and getting to know the resident;
- 2) Personal and responsive: focused on respect for who the resident was, communication involving social conversations with both residents and families – developed through a resident-centered approach to care which included finding

out what matters to the resident and knowing why it is significant for the resident;

3) Reciprocal: focused on negotiation and compromise and took the needs of staff, residents, and families into account within a trusting relationship – developed through a relationship-centered approach to care which included developing shared understandings between staff, residents, and families (p. 1749).

The pragmatic type of relationship received the most negative results because the quality of the relationships was not the main focus (Wilson & Davies, 2009). Instead, it was focused on the practicalities of the tasks at hand and the resident's safety, making it appear as if nurses were not focused on the residents as individuals. Nurses were found to be using work routines as a means of learning about the resident. Although they were able to become familiar with personal routines and preferences of individual residents, the pressure of work allowed some preferences to be overlooked while focusing on the task. This made the work easier for staff but was not focused on the resident or the relationship. The resident-centered type of relationship included nurses listening to stories told by families or residents, conversing using photos or other personal items, recognizing details of personal care that were significant to each resident, and doing the 'little things' that have a large significance for residents (p. 1750). Combining the functional care approach with resident-centered care approach (pragmatic and resident-centered relationship types combined) and making it part of nurses' routines saves time, does not require 'extra' work for nurses, and facilitates getting to know the resident and improves the quality of care (p. 1753). However, for a therapeutic and meaningful relationship to abound, staff must offer themselves personally to residents to create this reciprocity. Some residents may be reserved or hesitant to forming new ties early after the transition. Nurses must offer themselves, not wait for the resident to initiate the relationship. This will also give residents more confidence in staff and ensure the formation of trusting relationships (Wilson & Davies, 2009).

It is a common sentiment that relationships are the foundation of quality care, and relations with staff in particular appear to be most central to resident's discussions of quality care and life in the LTCF (Coughlan & Ward, 2005). It was found that conversations and small talk with residents had immediate effects in improving attitudes and moods of the residents (Coughlan & Ward, 2005). Nursing staff provides close and intimate care, but it is often difficult for nurses to provide 'caring care' under the workload and time constraints of the current institutional work environment. Strategies and interventions that would benefit nurses most would ideally enable getting to know the resident while simultaneously providing routine care. Some simple interventions include searching for a connection between self and residents to build a close relationship, asking non-care related questions, being dependable, reliable, and trustworthy by following-up on concerns (Coughlan & Ward, 2005). Communication is key to developing a close relationship. Continuity of staff is also an effective way to maintain therapeutic relationships, however it is a factor that is not easily controlled or a reliable means of accomplishing this due to fluctuating staffing patterns (Coughlan & Ward, 2005).

The relationship that a nurse has with a resident's family member is almost just as important as their relationship with the resident. The nurse's role should always include working cooperatively with family and facilitating their participation in the care of their relative. A study by Bauer (2006) sought to understand the role of the family from the nurses' perspective. Some nurses "recognized the value of family input and provided support for the family in establishing their role, making reference to developing a detailed history of the resident's life and developing care contracts with family members" (p. 48). Family members wished for their relatives to be cared for as if they were relatives of the caregiver. However, staff often perceived there to be a clear division of labor and responsibilities, with the technical tasks belonging to the nursing staff

and emotional and social care being assigned to the role of the family (Bauer, 2006). Some also believed that families were not their responsibility, and that they are only being paid to care for the resident. Nurses consider engaging with the family another task on a long list required by their already heavy workload, therefore family “continued to be perceived as both ancillaries to care and obstacles and/or problems” (p. 49-50). Nurses should establish cooperative relationships with family members of the residents that they care for, by including the family in nursing home life and being flexible. Bauer (2006) proposes that nursing staff be trained on how to deal with families, because it is an inevitable part of the nursing profession and enhances person-centered care. Nurses may not realize it under the stress of their workload, but family assisting with the care of residents makes close person-centered care possible and also lightens the workload for nursing staff. Nurses can also learn useful personal information from the family members of residents (Bauer, 2006).

Maintaining relationships and forming new ones with friends and other residents is also a very significant aspect of ensuring adaptation to life in a LTCF for older adults. Many relationships are formed due to similar interests and participating in the same activities. It is an important aspect of the nurse’s role in understanding the importance of social stimulation in positive adjustment and facilitating the transition by assessing and assisting residents in maintaining and forming relationships with other residents. Many residents in Coughlan and Ward’s (2005) study stated that they often spent most of their time sitting around doing nothing alone, rather than participating in activities. In a study by Patterson (1995), “residents found that engaging in social interaction and activities made them feel as if they were provided with reciprocal social support that gave them a sense of purpose” (p. 688). Nurses can assist by encouraging residents to attend different functions, eat at a new table every night, or sit with

others who the nurse knows could potentially share similar interests and be compatible. If nurses know personal details about the resident, they can direct older adults to activities that they know they will enjoy, such as activities that are a continuation of life-long interests (Iwasiw et al., 1996).

As important as it is for residents to form new relationships and make new friends, it is equally important that they are able to maintain ties with acquaintances from outside the LTCF that they knew before the relocation. Rossen (2007) states that, “continued relationships are likely to contribute to positive adaptation” (p. 294). A nurse can be sure that residents maintain contact with those people who are important to them by assisting older persons to identify who they would like to remain in contact with and to problem solve ways they can do that such as weekly telephone calls, sending notes/letters, and inviting people to dinner (Rossen, 2007).

Another issue that frequently takes place in LTCFs is population mixing. In a study by Iwasiw et al. (1996), some residents were uneasy when around residents who were cognitively impaired. It is important for nurses to keep in mind that residents who have significant differences in cognitive disabilities will not be able to effectively communicate and may not be compatible and should possibly not sit together during meal time so as to avoid hindering valuable social interaction.

Type/Characteristics of the Transition. Ten of the studies included in the literature search discussed the type and characteristics of the transition experience as having a profound effect on the resident’s adjustment. In a study seeking to identify factors that influence individual responses to transition, Young (2010) determined that many factors relating to the transition can influence how one adapts, including “predictability and controllability, whether the move is voluntary or involuntary, the extent of environmental change, and the timing and duration of

relocation” (p. 77-78). It was also found that when the move to LTC was an involuntary decision made on the resident’s behalf, a poorer transition was experienced. However, it is important to remember that every individual older adult will react and perceive the move differently (Young, 2010). Whether the move was planned or unplanned is often one of the most influential contextual factors that determines how well an older adult will adapt to the transition. Wilson (1997) states that knowing whether the move was planned or unplanned will provide a basis for developing interventions to ease the transition process for older adults.

Planned transitions to long-term care almost always have more favorable outcomes for the older adult than unplanned relocations. In a study based on resident’s perspectives two weeks after moving into a LTCF, it was found that residents who participated in the decision experienced a smooth transition, in contrast to those whose decisions were made by family members or healthcare providers tended to resist the change (Iwasiw et al., 1996, p. 384). This may be because “persons who planned for the move to a nursing home had time to consider various options in relation to declining or changing physical, social and financial resources” (Wilson, 1997, p. 864). Another study had similar results, in which older adults who planned for the transition started working on “the process of adjustment” before admission, and therefore progressed through the phases of transition more quickly than those who did not (Wilson, 1997).

Unplanned admissions had more negative outcomes as evidenced in the study by Iwasiw et al. (1996) in which “feelings of sadness, depression, anger, powerlessness, and betrayal were expressed by four residents who felt they had no choice about their admission” (p. 383). This may be because “the unplanned admission to a nursing home is most often a result of a person experiencing a sudden deterioration in health, hospitalization, inability to care for themselves, and having families who are unable to provide care even with the support of home care agencies”

(Wilson, 1997, p. 864). In a study by Wilson, three phases of transition were identified: 1) Overwhelmed, 2) Adjustment, and 3) Initial Acceptance Phase. The length of time one spends in a particular phase depends on the context and circumstances surrounding the transition. It was found that, “for older adults who had not planned on nursing home admissions it was too many changes at one time. The phase of being overwhelmed lasted longer for the eight older adults whose admissions were unplanned” (p. 869). Older adults who had not planned on entering a nursing home took longer to make the transition and experienced more emotional responses. It is imperative for health care personnel to recognize that older adults who experience an unplanned admission may need a longer period of time to adjust (Wilson, 1997). A nurse can focus his or her care on the areas that were unplanned to ameliorate the negative feelings and emotions associated with them (Rossen, 2007).

The precipitating events that lead to both unplanned and planned nursing home admissions are usually negative or traumatic events that take time to cope with and adjust to, in addition to the transition. Precipitating events often include a decline in health status, decrease in functional ability, and relieving the burden from family caregivers (Iwasiw et al., 1996). Whether the move to a LTCF is planned or unplanned, the precipitating events are almost always unplanned, unpleasant, and uncontrollable. These “uncontrollable events tend to elicit more cognitive and emotion-focused processes. If entering a nursing home is perceived as an uncontrollable event, avoidance, denial or resigned acceptance may be used” (Oleson & Shadick, 1993, p. 482).

For many older adults the transition can involve the loss of a spouse. This is probably one of the most upsetting and emotionally destructive precipitating events that can occur for an older adult prior to the transition. Knowing this information and acknowledging the grieving

experience that must occur is crucial for a nurse to take into consideration when attempting to intervene during the transition process. After a traumatic experience such as the loss of a life partner, an older adult may not be functioning at their baseline because they are more concerned and focused on the death and loss of their spouse rather than the transition. Paying attention to the stage of the grieving process the older adult appears to be in can assist the nurse in deciding which interventions would be appropriate for the individual at that specific time.

The origin of the transition (whether one is admitted from home, hospital, or another short term LTCF) and the events surrounding the admission vary for every older adult admitted to LTC. A study by Kao et al. (2004) suggests that older adults admitted to nursing homes from the hospital may experience a tougher transition. The authors state that older adults admitted from the hospital is often misleading because the fact that they were living in their own homes prior to the hospitalization is not considered as an influential factor. However, this means that the older adult has already experienced one or more transitions that will build upon one another, resulting in an accumulation of stress over a short period of time (Kao et al., 2004). Is it accurate to assume one origin of transition is more stressful than another? Different issues that cause stress need to be considered depending on where an older adult's transition originated.

Regardless of where one is transitioning from, there are multiple possible stressors that an older adult can encounter, however some authors argue that transitioning from home may be the most stressful transition because it is also associated with personal losses, including the home itself and precious belongings (Kao et al., 2004). A study by Walker et al. (2007) addressed the difference of experiences that older adults experienced when transitioning from an assisted living versus a nursing home in their study on relocation stress syndrome (RSS). They found that nursing home residents more often experienced a disabling condition prior to relocation. Is there

truly a profound difference in experience of transitions to and from both types of facilities?

Walker et al. (2004) found that regardless of the type of facility from which the transition originated, the residents' responses were similar between nursing homes and assisted living facilities.

Achterberg et al. (2006) also conducted a study on the effects of the origin of transition and agreed with the findings of Kao et al. (2004). They found that transitions that originate from home are more difficult to adjust to because of personal losses, however these authors included the loss of autonomy and confidence as well (Achterberg et al., 2006). Their study was based on the prevalence of depressive symptoms in older adults transitioning into LTC, differentiated into groups by their origin of transition: home, hospital, or residential facility (Achterberg et al., 2006). Their findings concluded that residents admitted from private homes were observed to have more depressive symptoms than older adults who were admitted from another LTCF or from the hospital (Achterberg, 2006). They presume that, patients transitioning from the hospital may perceive the move to a LTCF as an "upgrade", as opposed to those leaving the comfort of their own homes and that those coming from the hospital also have a greater change of being a "temporary resident" (p. 1160). This however may not be how older adults view their experiences in reality. The authors base this assumption on the fact that "the latter group [those originating from the hospital] might have entered the first two adjustment phases (disorganization and reorganization) already in the hospital, and start with the next adjustment phases earlier than the other residents" (p. 1161). However, it is important to question the presence of depressive symptoms before admission in these groups. Kao et al. (2004) believe that "if a resident is being admitted from his or her home, the environmental changes may be more radical, both physically and emotionally" (p. 15). Different needs should be addressed depending

on the origin of transition. For example, if the transition originates from home, there will not need to be as much care coordination (as if transitioning from a hospital), but more environmental modification and vice versa (Kao et al., 2004).

Preconceived notions and expectations can have a profound impact on the perspectives and the experience an older adult has when transitioning into a LTCF. In a study by Lee (2010), it was found that, “resident’s preconception about nursing homes was a significant predictor of overall adjustment. Residents who had a better preconception of nursing homes more easily adjusted to nursing home life” (p. 962). It is common knowledge that institutional care facilities such as nursing homes carry with them a negative stigma. In Walker et al.’s study (2007), the authors supposed that, “the negative public opinion regarding long-term care facilities, particularly nursing homes, probably influenced resident perceptions” (p. 44). Oleson and Shadick (1993) state, “preconceived notions must be discarded” because “effective coping with this transition requires effective management of negative aspects of the event” (p. 481). However, these preconceived notions cannot be discarded as easily as Oleson and Shadick suggest. The nurse has an important role of promoting positivity and keeping in mind that his or her attitude exhibited during care has a profound effect on the older adult and their perspectives of their care.

Discussion

For nurses to successfully facilitate the transition to long-term care for older adults, they must make themselves familiar with, and understand all the aspects surrounding the transition experience for each individual. Therefore, focusing on the transition experience for an individual is paramount to determining which interventions will be most effective for each older adult. As Young (1990) states,

The primary purpose of using the transition framework in the care of individuals during relocation is that it sensitizes the clinician to the experience as process and highlights potentially important features. As a clinician, then, sensitivity to the individual nature of the relocation transition is critical in understanding a given person's response (p. 80).

Brandburg (2007) developed a "Transition Process Framework" that describes logistically what phases/stages an older individual experiences and progresses through during the transition into long-term care. Although models depicting the phases/stages of the transitional experience are useful tools that the nurse can use to familiarize him/herself with the process and understand the experience of transition from the resident's perspective, they do not provide a guide to practice. Brandburg (2007) suggests that transition frameworks can benefit nurses by providing them with insight on how to assess and evaluate individual older adults' response to the transition, as well as developing "phase-specific interventions" to facilitate a smooth transition (p. 55-56). Brandburg (2007) provides the following example, that residents in the initial reaction phase may need time alone to reflect instead of attending numerous activities whereas residents in the adjustment phase may be interested in participating in social activities as they develop new relationships. Using the transition process models as a guide is effective to determine when and which specific interventions would be most effective, because it depends on what phase of the transition the resident is currently experiencing. This requires the nurse to possess astute assessment skills, individualization, and sensitivity (Brandburg, 2007).

Person-centered care and individualization of care are at the center of the model because all older adults will experience the transition differently. Nurses must exercise caution when utilizing transition process models because not all older adults will progress through the stages at the same rate. It has been found in a study that older adults in a LTCF "seemed to be experiencing aspects of more than one phase simultaneously. Therefore, caution should be

exercised in expecting residents to adjust in a precise, step-wise sequence; nor should any one behavior be the basis for viewing a resident as being in a particular phase of adjustment” (Iwasiw et al., 1996, p. 386).

Wilson (1997) confirmed in a study that residents appreciated having someone to confide in to share the details of their experience during the transition process. Wilson recommends the following:

Nursing homes should designate a staff member or volunteer to interact with older adults who are experiencing the transition to nursing home life. This person should have good interviewing skills, be empathic and supportive. The older adult should be seen at regularly scheduled times during the initial period of the transition to the nursing home. It is especially important that frequent contact takes place in the early stage of the transition as this is a time when older adults are adjusting to several changes. Frequency of visits could be reduced depending on the older adult’s response. The study findings suggest that this process may be beneficial in assisting older adults with the transition to nursing home life...Recognizing the phases of the transition to nursing home life...will assist health professionals in designing interventions to help older adults make this life transition (p. 870).

This description fits the role of the nurse perfectly. There is no better member of the healthcare team to facilitate this transition with compassionate care.

How can the proposed model of this thesis be tested? There are multiple ways in which the success of these interventions can be conducted and measured. A variety of approaches such as observational, relational, and testing/intervention trials should be explored and researched. There is also the question of how will successful transitions be measured? Wilson (1997) states that, “indicators of a healthy transition are subjective well-being, comfort with behavior in a new situation and well-being of relationships” (p. 869). However, quality outcome measures such as

patient satisfaction, quality of life, and factors of adjustment are all possibilities. In light of recent research, it has become evident that, “the focus of more recent research efforts on the impact of relocation on elderly people is shifting from mortality as a measure towards the effects of cognitive, functional and social abilities, the amount and types of psychological distress, social-environment factors and identification of populations at risk for experiencing negative effects” (p. 865).

Zubritsky et al. (2012) describes the concept of HRQoL (health-related quality of life), which includes factors of well-being, health status, and social support. The authors of this study developed a revised conceptual model of HRQoL specifically tailored for LTSS (long-term services and supports) to address the specific attributes associated with the population, such as, functional decline, both physical and cognitive, and the presence of multiple chronic illnesses (Zubritsky et al., 2012). It uses a subjective interpretation focus, used in combination with objective (medical) data for a holistic view of the patient’s QoL and perception (Zubritsky et al., 2012). This aspect of the model takes into account the changing priorities of what is considered important to older adults living in long-term care and their interpretations of quality of life, upholding the concept of person-centered care (Zubritsky et al., 2012). This modified model includes five core domains: biological and physiological factors, symptom status, functional status, general health perceptions, and perceived QoL. It has been expanded to include individual characteristics of cognitive and behavioral status and aspects of LTSS organizations such as environmental characteristics, in addition to including persons with impaired cognitive abilities (Zubritsky et al., 2012). A model such as this should be used to measure the effectiveness of the proposed model constructed from this thesis due to its emphasis on person-centered care and its support of individual patient perspectives.

Conclusion

It is hoped that the model developed from this thesis can produce a practical contribution, in which the suggested interventions can be incorporated into everyday practice for all nurses to refer to and utilize in their care of older adults experiencing a transition.

The limitations of this thesis include the sample of small qualitative studies used as basis for the model, however this is related to the state of the current available research. There are few studies that contain quantitative evidence of these approaches to care. There is also a need for longitudinal studies to determine the effects these interventions would have over time. A major limitation involves the lack of research conducted on transitions to long-term care in relation to older adults with cognitive disabilities such as dementia or Alzheimer's disease. In addition, many of the studies used in this literature review took place in various different countries and there is little understanding of how aspects of care related to transitions compare between different countries and if concepts are generalizable.

This model can also serve as a guide for future research, encouraging the exploration of topics such as how transitions differ between nursing homes versus assisted living, the differences experienced depending upon where the transition originates from, the unique challenges for cognitively and mobility impaired older adults, and how successful transitions can be measured.

Acknowledgements

Finally, I would like to acknowledge the tremendous effort and assistance I received from my two nursing faculty advisors, Dr. Janice Foust, and Dr. Suzanne Leveille. Without their continuous guidance, compassion, and genuine interest in my success throughout the entirety of this project, this thesis would not have come to be what it is now. I would also like to thank Dr.

Emily Jones, Dr. Laura Hayman, Associate Dean for Research, and Ms. Regine Paul, Office of Research Program Assistant, for their incredible assistance with the opportunity to present my thesis at the Eastern Nursing Research Society Conference.

Works Cited

- Achterberg, W., Pot, A.M., Kerkstra, A., & Ribbe, M. (2006). Depressive symptoms in newly admitted nursing home residents. *International Journal of Geriatric Psychiatry, 21*, 1156-1162.
- Baldauf, S. (January 12, 2010). These Nurses Care About Their Elderly Charges: At New-Culture Facilities, the Emphasis is on Respect for Residents and a Home-like Setting. *US News: Health*. Retrieved from: <http://health.usnews.com/health-news/best-nursing-homes/articles/2010/01/14/these-nursing-homes-care-about-their-elderly-charges>
- Bauer, M. (2006). Collaboration and control: nurses' constructions of the role of family in nursing home care. *Journal of Advanced Nursing, 54*(1), 45-52.
- Bowers, B., & Nolet, K. (2011). Empowering direct care workers: Lessons learned from the green house model. *Seniors Housing & Care Journal, 19*(1), 109-120.
- Brandburg, G. (2007). Making the transition to nursing home life. *Journal of Gerontological Nursing, 50*-56.
- Bridges, W. (1980). *Transitions*. Reading, MA: Addison-Wesley.
- Coughlan, R. & Ward, L. (2005). Experiences of recently relocated residents of a long-term care facility in Ontario: assessing quality qualitatively. *International Journal of Nursing Studies, 44*, 47-57.
- Ellis, J.M. (2010). Psychological transition into a residential care facility: older people's experiences. *Journal of Advanced Nursing, 66*(5), 1159-1168.
- Fraher, A., & Coffey, A. (2011). Older people's experiences of relocation to long-term care. *Nursing Older People, 23*(10), 23-27.

Heidegger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.) New York: Harper and Row (Original work published 1927).

Heliker, D., & Scholler-Jaquish, A. (2006). Transition of new residents: basing practice on residents' perspectives. *Journal of Gerontological Nursing*, 34-42.

Institute on Medicine. (2001). "Crossing the Quality Chasm: A New Health System for the 21st Century". Retrieved from:

<http://iom.edu/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf>

Iwasiw, C., Goldenberg, D., MacMaster, E., McCutcheon, S., & Bol, N. (1996). Residents' perspectives of their first 2 weeks in a long-term care facility. *Journal of Clinical Nursing*, 5, 381-388.

Kao, H.S., Travis, S.S., & Acton, G.J. (2004). Relocation to a long-term care facility: working with patients and families before, during, and after. *Journal of Psychosocial Nursing*, 42(3), 10-16.

Lee, G.E. (2010). Predictors of adjustment to nursing home life of elderly residents: a cross-sectional survey. *International Journal of Nursing Studies*, 47, 957-964.

Mather, K.F., Bakas, T. (2002). Nursing assistants perceptions of their ability to provide continence care. *Geriatric Nursing*, 23(2), 76-81.

McGilton, K.S., & Boscart, V.M. (2007). Close care provider-resident relationships in long-term care environments. *Journal of Clinical Nursing*, 16, 2149-2157.

Medicare.gov. (2012). *Long-term Care*. Retrieved from:

<http://www.medicare.gov/longtermcare/static/home.asp>

- Oleson, M. & Shadick, K.M. (1993). Application of Moos and Schaefer's (1986) model to nursing care of elderly persons relocating to a nursing home. *Journal of Advanced Nursing*, 18, 479-486.
- Patterson, B.J. (1995). The process of social support: adjusting to life in a nursing home. *Journal of Advanced Nursing*, 21, 682-689.
- Rantz, M.J., Porter, R.T., Chesier, D., Otto, D., Servey III, C.H., Johnson, R.A., Aud, M., Skubic, M., Tyrer, H., He, Z., Demiris, G., Alexander, G.L., & Taylor, G. (2008). Tiger Place, a state-academic-private project to revolutionize traditional long-term care. *Journal of Housing for the Elderly*, 22(1/2), 66-85.
- Rossen, E.K. (2007). Assessing older persons' readiness to move to independent congregate living. *Clinical Nurse Specialist*, 21(6), 292-296.
- Sacco-Peterson, M., Borell, L. (2004). Struggles for autonomy in self-care: the impact of the physical and socio-cultural environment in a long-term care setting. *Scandinavian Journal of Caring Science*, 18, 376-386.
- Starfield, B. (2011). Is patient-centered care the same as person-focused care? *The Permanente Journal*, 15(2): 63-69. Retrieved from:
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140752/>
- Walker, C.A., Curry, L.C., & Hogstel, M.O. (2007). Relocation stress syndrome in older adults transitioning from home to a long-term care facility: myth or reality? *Journal of Psychosocial Nursing*, 45(1), 39-45.
- Wiersma, E.C. (2010). Life around...staff's perceptions of residents' adjustment into long-term care. *Canadian Journal on Aging*, 29(3), 425-434.

- Wilson, C.B. & Davies, S. (2009). Developing relationships in long term care environments: the contribution of staff. *Journal of Clinical Nursing, 18*, 1746-1755.
- Wilson, S.A. (1997). The transition to nursing home life: a comparison of planned and unplanned admissions. *Journal of Advanced Nursing, 26*, 864-871.
- Young, H.M. (1990). The transition of relocation to a nursing home. *Holistic Nursing Practice, 4* (3), 74-83.
- Zubritsky, C., Abbott, K.M., Hirschman, K.B., Bowles, K.H., Foust, J.B., & Naylor, M.D. (2012). Health-related quality of life: expanding a conceptual framework to include older adults who receive long-term services and supports. *The Gerontologist*, *doi:10.1093/geront/gns093*