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THE EFFECTS OF ORIENTATION TO AN EXTENDED CARE FACILITY
ON THE ELDERLY PERSON'S ADAPTATION TO THE PATIENT ROLE

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Master of Science degree in Nursing

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THE EFFECTS OF ORIENTATION TO AN EXTENDED CARE FACILITY
ON THE ELDERLY PERSON'S ADAPTATION TO THE PATIENT ROLE

By

Janet Lee Elgood

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ABSTRACT

THE EFFECTS OF ORIENTATION TO AN EXTENDED CARE FACILITY
ON THE ELDERLY PERSON'S ADAPTATION TO THE PATIENT ROLE

By

Janet Lee Elgood

A descriptive study of 30 elderly individuals who relocated over a four month period from the acute care setting to a skilled nursing facility in the Midwest was completed. A retrospective medical record audit was performed on 22 of the participant's medical records and the individuals were described according to sociodemographic characteristics, physical health status, social status, communication status, and status relative to prior nursing home familiarity. A description was completed of the remaining eight study participants based upon pretest data from the original intended experimental study design. Mean scores and percentages were reported relative to the number and type of characteristics of the newly admitted skilled nursing facility population. The conclusions of this study were drawn relative to the findings of the audit and the pretest data which was obtained from eight of the participants.

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CHAPTER I

The Problem

Introduction

Interinstitutional relocation of the elderly is a traumatic event (Mirotznik & Ruskin, 1984; Pino, Rosica & Carter, 1978; Yurick, Robb, Spier, & Ebert, 1984). Relocation of the institutionalized elderly has been viewed as both resulting in an increased morbidity and mortality (Pastalan & Bourestom, 1977; Thomas, 1979), and as resulting in no significant increase in morbidity and mortality (Borup, Gallego & Heffernan, 1979). Therefore, although the event of relocation is viewed as a stressful or traumatic life event, more research regarding the issue of interinstitutional relocation is needed to ascertain the effects of the relocation event on the elderly individuals who are experiencing the move.

In 1982, there were approximately 1.3 million nursing home residents in the U.S. (Butler & Lewis, 1982). In 1985 "an estimated 1.4 million elderly Americans lived in nursing homes, and approximately 6.6 million Americans aged 65 and older were in need of long-term care indicating a 14% increase since 1980" (Day, 1985, p. 6). According to Day (1985), "the number is expected to grow at an even faster rate in the 1990's" (p. 6), and the number of elderly requiring institutional care can be expected to rise.

One possible explanation for the increased utilization of long-term care facilities by the elderly is the advent of DRG's (diagnosis-related groupings). As of 1984, hospital patients are

classified on the basis of diagnosis and the hospitals are concurrently paid a fixed amount per discharge based on the diagnosis of the patient. The DRG system is the basis for the concurrent payment method (known as the prospective payment system -- PPS) and is a method which "radically restructures the manner in which hospitals are paid for inpatient services provided to Medicare beneficiaries" (AMA, 1986). The DRG/PPS system's major objective "is to establish the government as a 'prudent buyer' of health care while maintaining beneficiaries' access to quality care" (AMA, 1986). However, an outcome of the DRG/PPS system is often a shortened length of stay in the acute care setting. Many of the elderly patients are too ill to return to their homes after a shortened hospital stay and may, therefore, be referred for nursing home placement.

Also reported in the literature is the phenomenon of the increased utilization of long-term care institutions by elderly individuals who are 85 years and older (Day, 1985; U.S. Senate, Special Committee on Aging, 1985). The population, 85 years and older, are those elderly individuals who are "most likely to suffer severe mental and physical impairments that are difficult for unskilled family members to care for at home" (Day, 1985, p. 7).

One of the major traumas of the last stage in the life cycle is the realization that the elderly individual can no longer independently care for himself/herself and must be relocated to an alternative living arrangement. According to Rowles and Ohta (1983) "much discussion has evolved on the notion of 'transplantation shock' or the 'relocation effect' experienced by elderly individuals upon

changing living environments" (p. 189). Two questions arise: Do all older people under all conditions experience negative consequences following a move, or are certain types of individuals more susceptible to a move under certain conditions? What, if anything, can be done to facilitate adjustment in a new setting and reduce the potential "transplantation shock"?

According to Engle (1985) "relocation, or moving from one environment to another, is potentially traumatic for the aged" (p. 355). Yurick, Robb, Spier and Ebert (1985) report that "relocation is a life change experienced by many aged persons and studies of the long-term effects of relocation on the mortality, health and well-being of the aged person have produced conflicting results" (p. 254).

Nirenberg (1983) reports that there are many inconsistencies among studies regarding the issue of relocation of elderly individuals to institutions. Such reported inconsistencies of the effects of relocation are related to "mortality rates, increase in disease, general physiological decline and signs of depression and withdrawal" (p. 673). Nirenberg also reports methodological difficulties in studies of the effects of relocation on the elderly, i.e., "inadequate control groups, non-random subject selection and use of mortality rate as the sole dependent variable" (p. 673). Therefore, Nirenberg concludes that there is a need for additional research in the area of relocation and its effects on the elderly population.

In reviewing the research regarding the effects of relocation on the elderly, it is evident that additional study is needed in this area. Further investigation must be pursued to define the effects of relocation on the elderly population and to delineate possible alternatives for addressing the issue in order to prevent unnecessary problems in relocation.

Purpose

Many of the research studies which have been completed regarding the effects of relocation on the elderly individual show that relocation is related to an increase in morbidity and mortality (Pastalan & Bourestom, 1977; Thomas, 1979). Fewer negative effects have been identified in other studies regarding the elderly individual who is experiencing relocation (Borup, Gallego & Heffernan, 1979; Pino, Rosica & Carter, 1978). The effects of relocation on the elderly are as follows: increases in disease, general physiological decline, depression and withdrawal (Nirenberg, 1983).

The idea for this study evolved from the premise that since researchers indicate that relocation often results in negative experiences for the elderly individual, use of a positive approach when dealing with an elderly client experiencing relocation could possibly reduce the negative consequences. In other words, the experience of relocation could be viewed as a positive experience if the approach to the relocation was positive. The positive approach to relocation was designed in this study as an orientation program.

However, due to a limited number of eligible subjects for the study, the orientation program was not completed on a significant number of participants. An additional research question was raised relative to the description of the characteristics of the skilled nursing facility population and a descriptive study was completed regarding those elderly individuals who are relocating to the skilled nursing facility from the acute care setting.

The effects of relocation of an elderly individual from the acute care setting to the extended care facility has been selected for study. Relocation from acute care to extended care is a common occurrence in which the elderly individual is perceived by others as experiencing a great deal of stress (Yurick, Robb, Spier, & Ebert, 1984).

Therefore, the purposes of pursuing the more specific issues involved in relocation of an elderly individual from the acute care setting to the extended care facility were:

1. To investigate the effects of relocation on an elderly individual's ability to adapt to the new environment when moving from an acute care setting to an extended care facility in terms of the patient's general well-being, both objectively and subjectively.
2. To investigate the feasibility of the introduction of an orientation program by a registered nurse to elderly individuals relocating from the acute care setting to the extended care facility.

3. To determine the effectiveness of an orientation program by a registered nurse for the elderly individual who is experiencing relocation from an acute care setting to an extended care facility.

Problem Statement

Relocation to alternative environments encompasses several types of moves, i.e., home to institution, institution to home, or interinstitutional moves. In order to narrow the focus of this broad concept, one issue has been selected for discussion. The issue is relocation from the acute care setting to the extended care setting or facility; more specifically: "What is the effect of an orientation program by a registered nurse from an extended care facility upon an elderly individual's adaptation to that facility upon being admitted from an acute care setting"?

Definition of Variables

The independent variable "orientation program" was defined by providing a definition of "orientation" and "program." "Orientation" was defined as "an adjustment or adaptation to a new environment, situation, custom, or set of ideas" (Morris, 1973, p. 926). "Program" was defined as "a plan of procedure: a schedule or system under which action may be taken toward a desired goal; a proposed project or scheme" (Gove, 1961, p. 1812). "Orientation program" was defined as a plan of procedure to assist a person in an adjustment or adaptation to a new environment or situation. The orientation program



provided to the elderly individuals who were relocating from the acute care setting to the extended care facility included an introduction to the facility's policies and procedures, a tour of the facility, and answering the patient's questions regarding the facility.

The dependent variable "more positive adaptation" was clarified by the definitions of "positive" and "adaptation." Adaptation was defined as "anything that is changed or changes so as to become suitable to a new or special use or situation (Morris, 1973, p. 14). Positive was defined as "characterized by or displaying certainty, acceptance or affirmation" (Morris, 1973, p. 1022). Therefore, "more positive adaptation" was defined as a certain, accepted or affirmed change which is accomplished so as to become suitable to a new situation. The patient who experiences "more positive adaptation" upon relocation will exhibit a change which is suitable to adapting to the new environment. The adaptation was viewed as an outcome of the process of moving and preparing for the move to the new location. The outcome of adaptation can be measured.

Since adaptation is viewed as an outcome, the outcomes which were to be measured to indicate whether the elderly patient had experienced a positive adaptation from the acute care setting to the extended care facility were:

1. Knowledge
2. Socialization

Mental status was to be measured upon admission and at one month after admission using the Short Portable Mental Status Questionnaire



(SPMSQ). In utilizing this tool to measure mental status, the researcher examined the elderly patient's mental status within 48 hours of relocation from the hospital to the extended care facility and again one month later to determine any change in status during this time. The researcher also noted any differences in change in mental status between the treatment group (those patients who participated in the orientation program) and the control group from measures taken upon admission and one month after admission.

Knowledge was to be measured by determining the knowledge level of the elderly patients upon admission and one month post-admission regarding the policies and procedures of the extended care facility. The elderly patients were tested utilizing a short questionnaire which addressed the knowledge level of the patient regarding the specific policies and procedures of the extended care facility to which they were transferring. The researcher examined any differences in knowledge level regarding the facility's policies and procedures between the treatment group and the control group. The treatment group participated in an orientation program which was developed to present the facility's policies and procedures and the control group did not.

Socialization was to be measured for both the treatment and control groups by examining the patient activity records at the facility for number of social activities attended by each patient in one month. The researcher was to examine the activity records for any differences in number of activities between the treatment and control groups. The social activity was to be measured from

admission until one month post-admission and the researcher was to review the records for changes in amount of socialization.

A positive adaptation for the elderly clients in this study was measured as:

1. An increased knowledge level as evidenced by the elderly client's improved performance on the knowledge questionnaire pretest to posttest.
2. An increase in socialization as evidenced by the elderly client's increase in social activity pretest to posttest.

Therefore, the hypothesis for the study was stated as: an elderly individual from an acute care setting who is provided an orientation program to an extended care facility by a registered nurse from that facility will experience more positive adaptation than an elderly individual from an acute care setting who is not provided an orientation by a registered nurse from that facility.

The more specific hypotheses for this study were:

1. An elderly individual from an acute care setting who is provided an orientation program to an extended care facility will demonstrate a higher level of knowledge regarding the facility's policies and procedures than an elderly individual from an acute care setting who is not provided an orientation program.
2. An elderly individual from an acute care setting who is provided an orientation program to an extended care facility will demonstrate a higher level of social activity than an elderly person from an acute care setting who is not provided an orientation program.

Assumptions and Limitations

Assumptions

The following assumptions were made in this study:

1. It was assumed that elderly individuals who were relocating from the acute care setting to the extended care facility were required to respond to change as a result of the relocation experience.
2. It was assumed that the effects of the relocation experience from the acute care setting to the extended care facility were different upon admission to the extended care facility than the effects 30 days after admission.
3. It was assumed that the elderly individuals who participated in the study were capable of responding cognitively to the questionnaires which were used as the measurement instruments.
4. It was assumed that the elderly individuals experiencing relocation from the acute care setting to the extended care facility viewed the relocation event as a significant and important life event involving adaptation.
5. It was assumed that changes in adaptation could be determined and assessed by measurement of knowledge and socialization.

Limitations

The following limitations were acknowledged in this study:

1. The elderly individuals who were relocating from the acute care setting to the extended care facility experienced differing lengths of stay in the acute care setting before transferring to the extended care facility.

2. The individuals who agreed to participate in the study did so on a voluntary basis and were randomly assigned and, therefore, the study results were not generalizable to non-volunteers.
3. The study participants were discharged from the acute care setting much sooner under the new procedure utilizing diagnosis related groups (DRG's) than clients who were subjects of related research in past years. Therefore, comparisons to past research regarding relocation from acute care to extended care settings may not be consistent. Also, study participants may have been too ill to complete the orientation program.
4. The participants who agreed to take part in the study initially may not have been available at the time of retest due to attrition.
5. The Director of Nursing of the extended care facility visited a small percentage of the clients in the acute care setting who were being transferred to the extended care facility. The Director of Nursing provided an informal orientation to the extended care facility to those patients who were visited.
6. The study participants may have experienced other losses in addition to the losses involved with relocation and may have reacted differently.
7. The level of accuracy of the social activity director was variable when she was recording daily activities.
8. One month may not have been long enough to make a positive adaptation to the extended care facility.



9. There was no control for physical health, i.e., more debilitated patients may have made a poorer adjustment.

Criteria for Inclusion in the Study

1. Age limitation. The participants in the study were 55 years of age or older.
2. Presence of family/significant other. All patients who were admitted to the extended care facility were required to designate a "responsible party" (a family member or significant other who is responsible for the patient's affairs).
3. Terminal illness. Presence of a terminal illness was considered in selection of patients in the study, but only as related to the inability of the patient to participate due to communication problems, physical weakness/deterioration or unwillingness to participate.
4. Diagnosed Alzheimer's or dementia patients were not included in this study.
5. Ability to speak and understand English was mandatory for participation in the study as the questionnaires were administered in interview format. Also, the respondents were capable of hearing or of having an interpreter available if deafness was an issue.
6. The participants were able to respond to the sociodemographic questionnaire and to the Short Portable Mental Status Questionnaire (SPMSQ) in interview format for determination of cognitive impairment.



Overview

This thesis is composed of six chapters. In Chapter I, the introduction, purpose, problem statement, hypothesis, definition of variables, and assumptions and limitations of the study are presented. The conceptual framework is presented in Chapter II, to include the definition and development of each concept.

Included in Chapter III are the purpose of the literature review (sectioned according to variables and/or major topic areas related to nursing and the study), and a summary of the literature.

In Chapter IV, Methodology and Procedure to include an overview, population, subjects, sampling technique, operational definition of the variables, instruments, data collection procedures, scoring of measures, a statement about protection of human subjects and data analysis techniques to be used are presented.

Data Presentation and Analysis are presented in Chapter V, to include a chapter overview, general descriptive data, data presentation for the hypothesis and summary of the findings. In the final chapter, Chapter VI, are the summary and interpretation of inferential findings, other findings, conclusions, to include implications for advanced nursing practice and primary care, recommendations, and tying of the research problem to the conceptual framework and previous research.

CHAPTER 11

Conceptual Framework

Overview

Interinstitutional relocation from the acute care setting to the extended care facility will be the focus of the following discussion. The format for the discussion encompasses a definition of the concepts, a statement regarding conceptual relationships, and development of a conceptual framework which integrates the Roy Adaptation Model of nursing.

Relocation

Relocation is defined as "moving from one environment to another" (Rowles & Ohta, 1983, p. 189) and "to establish in a new place" (Morris, 1983, p. 1099). Relocation also means "any change in the residential environment from one home or apartment in the community to another, from a community home or apartment to an institutional environment, and from one institutional setting to another" (Forbes & Fitzsimons, 1981, p. 263). Relocation is defined for the purposes of this discussion as moving from one environment (the acute care setting) to another (the extended care facility).

Wolanin (1978) describes "a study of a small hospital, who moved an elderly group (average age in the 80's and were defined as very frail)" who could not live without assistance to a new extended care facility which was connected to the hospital (p. 47). The nursing staff were provided a continuing education course on nursing care of

the geriatric patient which was completed prior to the move. The patients were provided an orientation program of two months duration prior to the move. The orientation program included taking the patients who were being transferred to lunch in the dining room of the new extended care facility every day. The patients were allowed to browse around the facility before and after lunch, to choose the room to which they would be moving, and to communicate freely about the move.

The move was very well planned and on the day of the move the patients were allowed to have breakfast, bathe and dress. Their families came in and participated in the moving process and the move was accomplished in time for lunch in the main dining room.

The success of the move was gauged by the patients' nighttime behaviors. The behaviors measured were: 1) sleeplessness; 2) confusion; 3) incontinence; and 4) wandering.

The results which were reported were: no sleeplessness, confusion incontinence or wandering. The move was considered to be a great success. The conclusions drawn by the researchers were that in relocation of the elderly, the patients must be informed, must participate in planning, must make choices, if possible, and the family and staff should be included in the move (Wolanin, 1978).

Nirenberg (1983) completed an experimental study which investigated interinstitutional relocation effects on forty subjects in a nursing home in North Carolina. The subjects were moving from an old facility to a new facility and Nirenberg viewed the relocation experience as a stressful life event for the subjects. The results

of Nirenberg's study indicated that administration of an orientation program in conjunction with a behavioral skills program (consisting of meetings with the subjects to teach them how to effectively deal with the relocation experience) led to a favorable relocation experience.

Pino et al. (1978) completed a study regarding the differential effects of relocation on nursing home patients. Pino et al. (1978) hypothesized that the patients who are relocated from another institution "will have more difficulty in readjusting than the transferred patient who has been prepared for the move, or the unprepared transferred patient" (p. 187). The result of the study by Pino et al. (1978) indicated that "prepared patients demonstrated less decline in mental alertness than other groups" (p. 172).

In the studies by Nirenberg (1983) and Pino et al. (1978), relocation, its effect on the elderly and prior preparation for the move are important considerations for a positive relocation experience. Also, the issue of relocation and its effect upon the elderly is discussed as a positive experience as opposed to a negative experience as the earlier studies on relocation indicated.

To further support the concept of more positive relocation effects, Giorella and Bevil (1985) reported that "relocation to a nursing home frequently involves the frail or ill old-old, making outcomes less certain" (p. 159). These authors suggest that if the relocation from facility to facility is well-planned, relocation is less likely to have ill effects.

Ebersole and Hess (1985) state that "the aged are more apt to be relocated than any other population segment" (p. 235). Therefore, these authors conclude that significant variables should be considered which relate to positive outcomes of relocation when relocation is defined as moving from one environment to another. For the purposes of this study, relocation is defined as moving from the environment of the acute care setting to the environment of the extended care facility.

In order to clarify the concepts of acute care setting and extended care facility within the definition of relocation, acute care setting is used synonymously with hospital and means a setting where the acute or immediate medical needs are met. Extended care facility is used synonymously with long-term care facility and means a setting where the recuperative, rehabilitative and supportive medical needs are met.

Orientation

The concept of orientation can be defined simply as "an adjustment or adaptation to a new environment, situation, custom, or set of ideas" (Morris, 1973, p. 926). The concept "orientation program" is defined as "a plan of procedure to assist a person in an adjustment or adaptation to a new environment or situation." The "orientation program" provided to the elderly individual who is entering the extended care facility includes a program provided on a one-to-one basis by a registered nurse who is familiar with the facility. The orientation program includes information about the



general operations of the extended care facility, and a review of the policies and procedures inherent to that facility. The categories of information include: type of organizational structure, political structure, type of nursing care delivery system, daily routine (as established by the facility), types of recreational programs, types of rehabilitative/restorative programs, Patients Rights, expectations of the patient/family and patient's expectations of the facility.

"Orientation" also refers to discussing concerns and answering questions which the elderly person may have about the facility. This type of discussion should include family members and/or significant others as appropriate. The orientation should be viewed as a "getting acquainted" period for both the individual and the nurse. The encounter should conclude with a feeling of mutuality about the exchange which has taken place. The elderly individual should view the encounter as a meaningful interaction in which all of his/her questions have been answered, and should be left with the feeling that he/she may call upon the nurse with further questions and/or concerns.

In order to view the concept of orientation as a measurable phenomenon and further define its use, specific measurement instruments must be utilized. According to the definition given earlier, orientation is defined as "an adjustment or adaptation...." (Morris, 1973, p. 926). Therefore, the tools which assess the elderly person's capability to adapt are those instruments which assess the process of adaptation. The elderly individual will adapt post-relocation by increasing his/her knowledge about the facility

and its operations and by socializing with family and the other residents at the facility.

In this study, the orientation program will be introduced. The effect of the orientation program on the elderly client will be determined by the measurement of how well the client has adapted. Adaptation will be measured in terms of the client's knowledge level before and after presentation of the orientation program and by amount of socialization post-relocation.

Orientation Programs

Prior to discussion of the measurement instruments, a discussion of the literature regarding the usefulness of orientation programs when dealing with the relocation of the elderly will be presented. Information is available in the literature regarding the issue of orientation of the elderly individual in preparation for admission to an extended care facility. For example, Ebersole and Hess (1985) found that among high-risk groups (those who are very old, with severe disabilities and apathetic affect), adaptation is enhanced by positive staff attitudes and morale and prior preparation for the move.

Mullen (1977) identified several other critical factors that reduce relocation or "transplantation shock." These factors include:

1. Prior cognitive mastery through tours, audiovisual presentations and a detailed advanced plan for the move.
2. A clear understanding of the extent of family involvement by the aged person, staff and family.

3. Joint decision making with the family and the aged individual.
4. Communications geared to the client's mental and sensory status.

According to Yurick, Robb, Spier and Ebert (1984) the steps which are identified when dealing with relocation trauma in the elderly are to:

1. Give the individual the opportunity for choice.
2. Give individualized preparation.
3. Do premove orientation to the new location.
4. Allow the person to participate in the decision making process.

Liben, Patterson and Newcombe (1981), in working with spatial relationships and the elderly, found that "'get acquainted' visits to the new environment did diminish the negative effects of forced relocation" (p. 364). Since there is support in the literature that "prior preparation" or "orientation" assists in promoting positive outcomes in relocation, it is important for those professionals and others (nurse aides, family members, trust officers, admission office personnel in the extended care facilities) who work with the elderly to further test and validate this premise. More specifically, for the purposes of this study, it is important to test the effectiveness of an orientation program in providing more positive adaptation for an elderly population who is being relocated from an acute care setting to an extended care facility. In this study, the orientation program will include:

1. A review of the Patient Bill of Rights.
2. A tour of the facility.



3. A review of the current policies and procedures of the facility (i.e., visiting hours, meal times, activity times, types of activities which are offered, etc.).
4. An opportunity for the participant to review any questions or concerns about the relocation experience with the researcher.

Adaptation

The researcher will attempt to determine whether or not presentation of the orientation program affects the adaptation of the elderly individuals. Whether or not the individual has adapted will affect the individual's relocation experience.

To define the concept of adaptation as it relates to the patient role in the new environment, Burnside (1980) addresses the issue in speaking about the "Fight Phenomenon." Burnside states that "the institutionalized aged persons are forced to learn to survive in a new setting at a point in time when they do not adapt readily; they become frustrated and angry" (p. 32). She goes on to say that it is the professional nurse's place to intervene before this phenomenon occurs by preventing anger, frustration and feelings of hostility from accumulating. Therefore, the older person seems to feel that "to pick a fight with or to complain belligerently to a truly powerful nonretaliatory person who will do something remedial does appear to enhance the ability of certain aged persons to cope with living in institutional settings" (Burnside, 1981, p. 53).

Ebersole and Hess (1985) also speak to the issue of the elderly person's adaptation to the patient role when relocating and they

identify ten variables which relate to positive outcomes of relocation. Five of these variables deal with assisting the individual to adapt to the new role, and the variables are:

1. Decision-making power is present.
2. Adequacy of new living situation including convenience to needed services.
3. Prior preparation to move.
4. Few concomitant stresses experienced.
5. Involvement of family or significant others (Ebersole & Hess, 1985, p. 235).

Grey (1978) found that "among high risk groups (those who are very old, with severe disabilities and apathetic affect) adaptation is enhanced by positive staff attitudes, morale and prior preparation for the move" (p. 38). Mullen (1977) also identified several factors which enhance adaptation and reduce "transplantation shock."

As previously discussed, the measurement of the patient's adaptation upon admission to the facility was accomplished using tools to measure adaptation ability. The measurement tools which were selected for this study were to measure adaptation abilities of the elderly individual by measuring knowledge about the extended care facility and socialization to the environment of the extended care facility.

Conceptual Framework

The Roy Adaptation Model of Nursing is the basis for the conceptual framework of this study. Briefly, the Roy Adaptation Model of Nursing can be explained as a model which "identifies the recipient of nursing care as an adaptive system" (Roy & Roberts, 1981, p. 43). Roy views this system as a composition of inputs, internal and feedback processes and output. The inputs are defined as stimuli which are fed into the adaptive system. The stimuli are processed in the regulator and cognator which are the two internal processor subsystems which deal with coping. The coping process is then effected through the four adaptive modes: physiological needs, self-concept, role function and interdependence. These modes are the mechanisms which "provide the particular form or manifestation of cognator and regulator activity" (Roy & Roberts, 1981, p. 43).

The physiological needs are defined as "the body's basic needs" (Roy & Roberts, 1981, p. 43); self-concept is "the composite of beliefs and feelings that one holds about oneself at a given time" (Roy & Roberts, 1981, p. 43); role function is "performance of duties based on given positions in society" (p. 44); and interdependence "involves one's relations with significant others and support systems" (Roy & Roberts, 1981, p. 44). These adaptive modes effect coping behaviors through physiological and psychological functions.

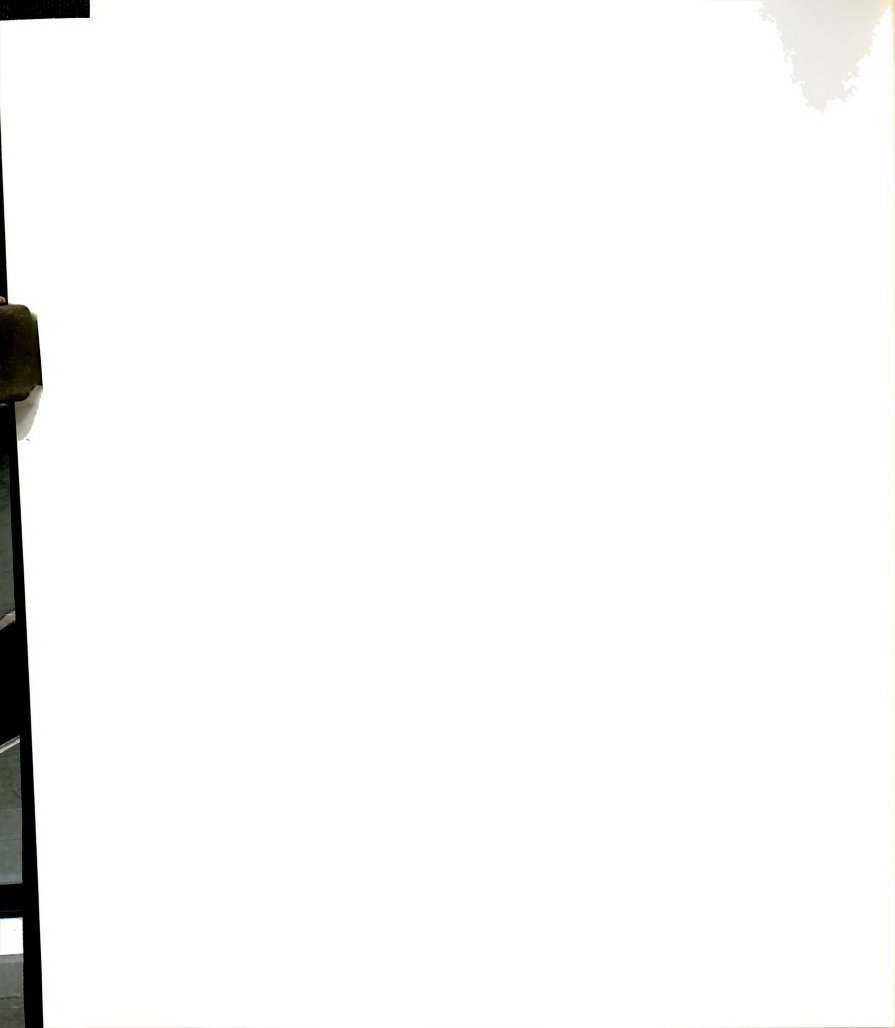
After the coping mechanism is effected through the four adaptive modes, which is the process phase of the system, the process ends with outputs or outcomes. The outcomes are expressed in Roy's Model as adaptive responses or ineffective responses. The adaptive

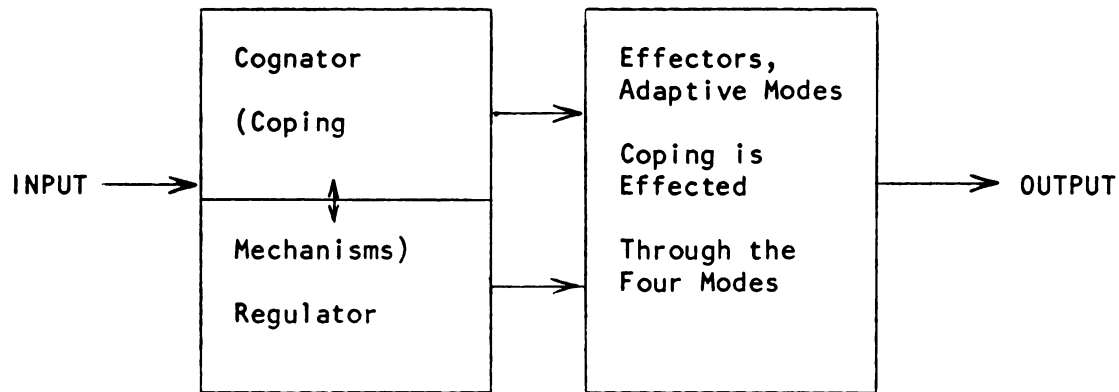
responses are those responses in which the individual has coped (process) and then adapted (outcome). The ineffective responses are those in which the individual has not coped (process) and, therefore, has not adapted (outcome).

In viewing the elderly individual who is involved in the relocation process, the person is viewed as an adaptive system. Burnside (1980) contends that upon relocation "the older patient usually has increased difficulty in adapting and adjusting to the rapidly changing environment, not only to the physical environment, but to the psychosocial one as well" (p. 103). Also, Burnside states that "the provision of a supportive environment in which patients are able to plan for their future helps them feel that they control their destiny" (p. 103), which again assists the individual to adapt.

An adaptive system is defined by defining the concepts of system and adaptation. System is defined simply as "a mechanism involving input, internal and feedback processes and output" (Roy & Roberts, 1981, p. 43). Adaptation is defined as "something that is done by living systems in interaction with their environment" (Roy & Roberts, 1981, p. 32). Adaptation may be viewed as an outcome or a process. Therefore, an adaptive system is a mechanism involving inputs, internal and feedback processes and output which is in constant interaction with its environment (Figure 1).

In Figure 1, Roy's conceptual model of nursing is represented. The items which are demonstrated as input are both internal and external stimuli. More specifically, these stimuli are the elderly individual's feelings regarding the move to the extended care





(Stimuli Adaptation Level:)

1. The elderly individual's feelings regarding the move to the extended care facility.
2. The reaction by the elderly individual to the family's and staff's attitudes about the move.
3. The physical effects of the move:
 - a. Presence of pain upon movement.
 - b. Weakness/fatigue.
 - c. Changes in bodily functions.
4. The mental status of the elderly individual.

(Adaptive and Ineffective Responses:)

1. Adaptation to the move. Increased knowledge and social activity.
2. Failure to adapt (to the move). Decreased knowledge and social activity.

Figure 1. The Person as an Adaptive System, adapted from Roy, C. & Roberts, S. (1981). Theory construction in nursing: An adaptation model, p. 58. Englewood Cliffs, NJ.

facility, the reactions by the elderly individual to the family's and staff's attitudes about the move, the physical effects of the move, (presence of pain upon movement, weakness and fatigue, and changes in bodily functions) and the mental status of the elderly individual.

The cognator and regulator are represented as the coping mechanisms and the adaptive modes are the effectors of the elderly individual's coping skills. The coping skills are then represented as effective or ineffective in the output phase. The outcome of the effective or ineffective coping by the individual is positive or negative adaptation to the move.

The elderly individual who is relocating from the acute care setting to the extended care facility is an adaptive system. The elderly individual as an adaptive system is very much affected by changes in environment and must constantly adapt in order to deal with the changes.

One disadvantage in the outcome upon relocation of the elderly individual is that his/her health is compromised in some way. As is suggested in the literature (Ebersole & Hess, 1985; Pino et al., 1978; Pastalan & Bourestrom, 1977; Wolanin, 1978), this compromise weakens the coping and adaptation capability of the elderly individual. Therefore, the individual is not functioning at his/her normal adaptive potential.

According to Mullen (1977), "adequate medical treatment before, during and after the move may mitigate some of the stressful effects of the move" (p. 13). Striving to achieve an optimal level of health

for the elderly individual will provide for more positive adaptation upon relocation.

The intervention by Mullen (1977) is viewed as input when applying it to the Roy Model. The intervention of "medical treatment" is seen as input from external stimuli (Roy & Roberts, 1981). The medical care team is viewed in this situation as manipulating the external variables and the individual is seen as providing internal stimuli in regard to his/her reaction to his/her current health status.

Roy, according to Fitzpatrick and Whall (1983) further defines stimuli and speaks of focal, contextual and residual stimuli. Focal stimuli is "the stimuli immediately confronting the person" (p. 159). Contextual stimuli is "all other stimuli which are present" (p. 159), and residual stimuli is "factors from past experiences which may be relevant to the present situation but whose current effect cannot be validated. These factors include beliefs and attitudes" (Fitzpatrick & Whall, 1983, p. 159).

In dealing with relocation from the acute care setting to the extended care facility, the elderly individual is dealing with several other types of stimuli as well as the issue of compromised health. He/she is dealing with such stimuli as past experience with relocation (residual stimuli), coping ability in dealing with change (contextual stimuli) and feelings and emotions about his/her current situation (focal stimuli). All of these stimuli affect the way in which the elderly individual will deal with the issue of relocation.



According to Mullen (1977) and Ebersole and Hess (1985), there are many significant variables which affect how the elderly adapt to the relocation process. First, the elderly must process the stimuli and accept those stimuli in the form of input, according to Roy's model. Next, the input is dealt with in the primary subsystems of the regulator and cognator, and in the secondary effector or subsystems (Fitzpatrick & Whall, 1983).

The regulator is related predominantly to the model of physiological needs and the major parts of the subsystem are the neural, endocrine and perception-psychomotor portions (Roy & Roberts, 1981). The cognator subsystem relates to all four adaptive modes and the major parts are "the psychosocial pathways and the apparatus for: 1) perceptual/information processing; 2) learning; 3) judgment; and 4) emotion" (Roy & Roberts, 1981, p. 62).

The processes of both the cognator and regulator are identified in propositions which depict the relationships between the individual and each of the subsystems. "The two systems are linked together in the process of perception" (Roy & Roberts, 1981, p. 67). The secondary effector subsystems consist of the four adaptive modes: 1) physiological needs; 2) self-concept; 3) role function; and 4) interdependence. "These modes will provide the particular form or manifestation of cognator and regulator activity" (Roy & Roberts, 1981, p. 66-67).

Therefore, the elderly individual processes all of the input information into the cognator and regulator subsystems. The



manifestation of the response to this processing of information will be seen in the adaptive modes.

The elderly individual who is relocated from the acute care setting to the extended care facility will deal with the input information through mental and physical processes. The perception process will then effect the adaptation.

The elderly individual generally perceives the issue of relocation as stressful and will effect this perception of relocation as a stressful event through the four modes:

1. Physiological needs. According to Burnside (1980), to help persons with limited neurological functioning (such as the elderly) to adjust and accept change, we would have to retain much of what was familiar. Or, according to Wolanin (1978), such physiological issues as vision must be taken into consideration when relocating the elderly, and plans to compensate must be formulated when function is poor.
No matter what the physiological problem is, the elderly individual should be assisted in adaptation to the physical problem first and then assisted with the adaptation to the new environment.
2. Self-concept. According to Burnside (1980) "the elderly institutionalized patient is often unable to cope with all of the stimuli within the environment and has a low self-esteem" (p. 103). The elderly individual in the acute care setting who is transferring to the extended care facility is often functioning at this level.

3. Role mastery. According to Burnside (1980), the newly admitted nursing home resident is faced with new role challenges:

- a. Orienting himself or herself to the facility.
- b. Living in a group.
- c. Coming to grips with loneliness and dependency.

The elderly involved in relocation will experience adjustment to acquisition of an entirely new role.

4. Interdependence. When an elderly individual is confronted with the issue of relocation, the relocation process is viewed as a multifaceted one in which the individual experiences dependency and interdependency, but experiences little independence.

According to Lesnoff-Caraveglia (1980), "the process by which the environmental change is effected and the nature of the environment are as important as the change itself" (p. 185). Therefore, the elderly are bombarded by several changes which evoke dependency needs which are often seen as negative behaviors by the elderly. These needs can take on a more positive focus by becoming interdependent needs, whereby the patient, family and professional are all working together toward a positive relocation experience.

According to Roy (Roy & Roberts, 1981), after the four adaptive modes "interact" with the regulator and cognator, responses are effected which are either adaptive or ineffective and are termed output. These responses, whether negative or positive, are fed back to the input for further processing and are added to the adaptation level as stored knowledge.

The elderly individual will exhibit responses to the relocation from the acute care setting to the extended care setting. The responses may be adaptive or ineffective in nature. An adaptive response would be a quick and positive adjustment to the move which promotes the integrity of the individual. In this type of response the individual will exhibit positive adaptation.

An ineffective response can be manifested in a number of ways, i.e., the "Fight Phenomenon," depression, withdrawal, death, etc. This type of response disrupts the integrity of the individual and the individual exhibits negative coping behavior, and maladaptation.

Both types of responses will influence the elderly individual's adaptation to the new environment. When unusual stressors or weakened coping mechanisms make a person's usual attempts to cope ineffective, then the person needs a nurse. Therefore, it is the responsibility of the nurse to intervene and "manipulate the stimuli so that they fall within the patient's zone of positive coping" (Roy & Roberts, 1981, p. 47).

In dealing with the issue of relocation and the elderly, "the professional nurse is the appropriate person to assess the situation of the elderly patient and to plan appropriate interventive strategy" (Burnside, 1980, p. 32). Therefore, the nurse can assist with the adaptation to the relocation process through interventions which will enhance the elderly individual's coping capabilities. One method of intervention is the provision of an orientation program to the extended care facility by a professional nurse who is familiar with that facility. In providing an orientation program to the extended



care facility, the professional nurse is manipulating the type and amount of stimuli which is provided for the patient. By manipulating the stimuli the professional nurse is able to affect the type of input which the individual receives.

In accordance with Roy's Adaptation Model, the orientation program will be administered as an external stimulus. The elderly individual will accept the program as input and process it through the cognator and regulator subsystems. The processed information will be perceived by the individual and effected in the four adaptive modes:

1. Physiological needs. The person's neurological system will respond to the orientation program as presented by the professional nurse, and a body response will be effected.
2. Self-concept. The elderly individual will view the new information from the orientation program and will experience a change in self-esteem and self-awareness.
3. Role mastery. The elderly individual will process the new information from the orientation program and will integrate the information in preparing his/her new role.
4. Interdependence. The elderly individual will recognize the reciprocal nature of this relationship with the professional nurse through participation in the orientation program. The nurse can reinforce this relationship through effective communication.

After the orientation program is presented, the output will be viewed as positive adaptation or as negative adaptation to the newly

acquired patient role after relocation. The output will then be fed back to the input component in the form of newly obtained knowledge.

The model is developed in such a way that when the output information is fed back through the feedback process, the professional nurse can make an assessment at that point and provide another intervention as needed. At this point, the interventions of the nurse become part of an ongoing process. The ongoing process in the model is easily assimilated with the nursing process (Figure 2).

In Figure 2, a flow chart illustrating the nursing process based on the Roy Adaptation Model of Nursing is represented. Application of the nursing process to the issue of relocation from the acute care setting to the extended care facility by an elderly individual is applicable to this representation. The first level assessment is representative of the client's behavior in each adaptive mode and the second level assessment is representative of the focal, contextual and residual stimuli (see examples, Figure 2). Problem identification is represented by a statement that the elderly individual has adapted effectively/ineffectively to the move. Goal setting is explained as the behavioral outcome for the client. The elderly individual will effectively adapt to the relocation from the acute care setting to the extended care facility. The intervention is represented by the orientation program and the evaluation is represented by measurement of adaptive behaviors: sociability and knowledge. The adaptive behaviors are outcomes of the effects of relocation and/or the orientation program on the elderly individual.

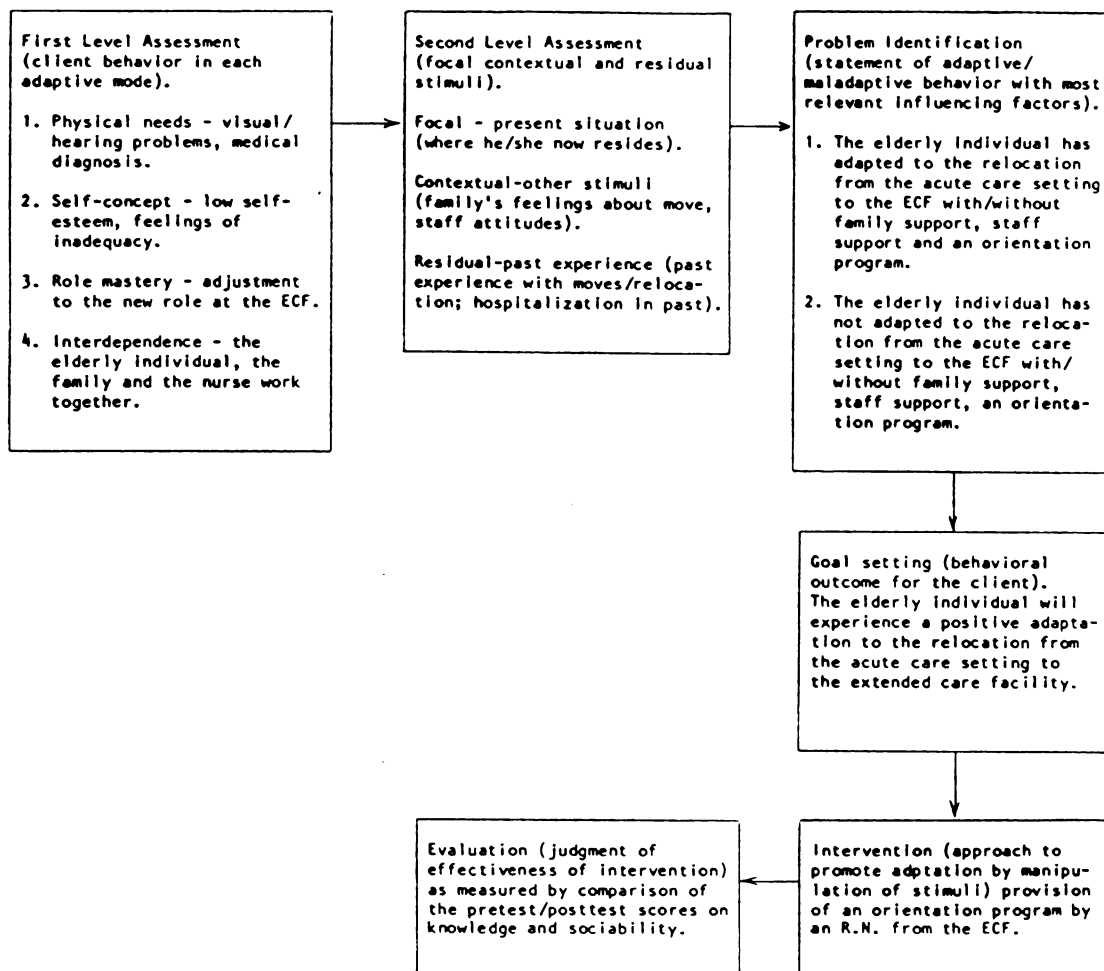


Figure 2: Flow Chart Illustrating the Nursing Process Based on the Roy Adaptation Model of Nursing, adapted from Roy, C. (1976), Introduction to nursing: An adaptation model, p. 38. Englewood Cliffs, NJ.

Therefore, the model is easily applied to professional nursing practice through application of the model to the nursing process. The professional nurse can assist the elderly individual who is relocating from the acute care setting to the extended care facility through adaptation of the conceptual framework which has been developed in this discussion.

In the primary care setting the Clinical Nurse Specialist can utilize the model directly by addressing the elderly client's and the family's needs when faced with relocation from the acute care setting to the extended care facility. The Clinical Nurse Specialist's role is to identify the client's and family's needs through assessment of the adaptive modes and the various stimuli which are present. The Clinical Nurse Specialist also identifies the problem(s) associated with the relocation event, provides assistance in goal-setting for the client and significant others, provides intervention strategies, i.e., the orientation program to the extended care facility and evaluates the effectiveness of the intervention in the relocation event.

The Clinical Nurse Specialist in the primary care setting may also effect several role characteristics to enhance the relocation experience for the client. The Clinical Nurse Specialist may broaden the scope of the event through education of other health team members from the acute care setting and extended care facility who are involved in the event.

One of the roles of the Clinical Nurse Specialist during the relocation of an elderly client from the acute care setting to the

extended care facility is the role of advocate. The Clinical Nurse Specialist functions as an advocate "by creating a climate of mutuality in which the nurse assists the client in exercising his/her rights and in improving self-care abilities" (MSU Graduate Student Handbook, 1980, p. 22). In the relocation situation the nurse encourages the client to exercise his/her rights to identify factors which will make the move a more positive experience. In doing so, the Clinical Nurse Specialist functions also as an educator.

Other role characteristics exhibited by the Clinical Nurse Specialist in the primary care setting when dealing with an elderly client who is experiencing relocation are the roles of assessor, planner, counselor, collaborator and coordinator. Utilization of these role characteristics serve to enhance the relocation experience for the client.

As assessor, the Clinical Nurse Specialist "utilizes a data base to identify health care needs" and as a planner "develops goal-directed strategies in collaboration with the client to facilitate maintenance and achievement of health-oriented goals" (MSU Graduate Student Handbook, 1980, p. 23). The Clinical Nurse Specialist would coordinate and direct the relocation experience with the elderly client and the client's family providing the necessary input to accomplish the client-centered relocation experience effectively.

Similarly, the Clinical Nurse Specialist as consultant and collaborator would enhance the elderly client's relocation experience. The Clinical Nurse Specialist would educate the nursing

staff regarding the effects of relocation from an acute care setting to an extended care facility on the elderly client. As collaborator, the Clinical Nurse Specialist would work with the acute care and extended care health team members "to achieve joint responsibility and accountability for planning and for decisions made regarding client needs and outcomes" (MSU Graduate Student Handbook, 1980, p. 22).

The framework which has been developed in this paper is easily applied to the primary care setting. The framework is applied to the conceptual model through synthesis with the Roy Adaptation Model and the model can then be integrated and applied to the nursing process for use in professional nursing practice (Figure 3).

Figure 3 is representative of Figures 1 and 2 in combined form. The Roy Adaptation Model of nursing and the illustration of the nursing process based on the Roy Adaptation Model of Nursing can be presented through integration of the individual representations. The outcome is the model for the effect of orientation on the elderly individual in relocation from the acute care setting to the extended care setting as applied to the Roy Adaptation Model of Nursing and as integrated with the nursing process.



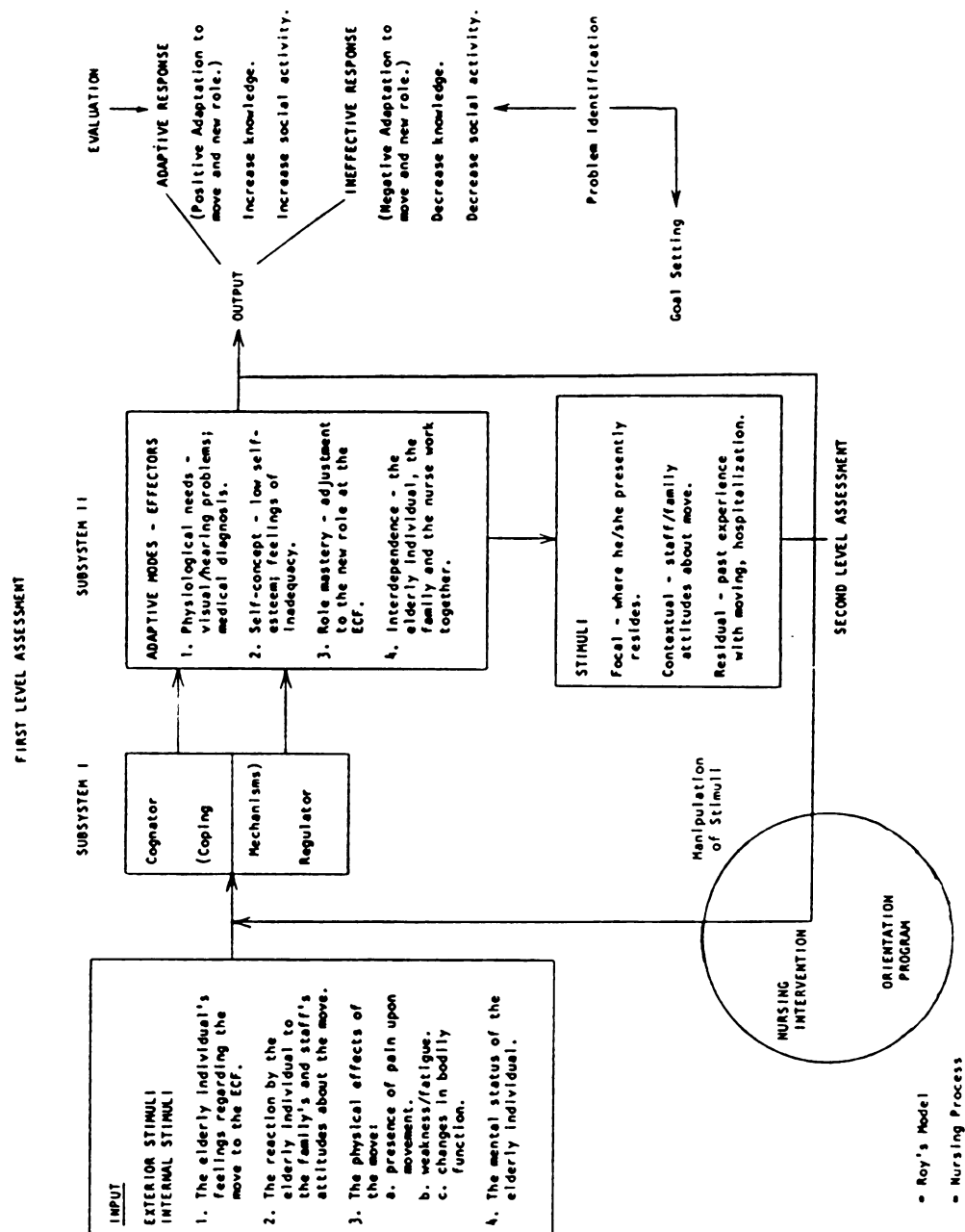


Figure 3: The Effect of Orientation on the Elderly Individual in Relocation from the Acute Care Setting to the Extended Care Facility as applied to the Roy Adaptation Model of Nursing and integrated with the nursing process.

CHAPTER III

Review of the Literature

Introduction

The purpose of this chapter is to present a scholarly review of the literature regarding the major variables in this study. The studies which will be identified are related to: interinstitutional relocation of the elderly, adaptation and orientation programs for elderly individuals who are experiencing relocation. Also discussed are the concepts of knowledge and socialization as a part of adaptation. Included in the review will be discussion of both the content and the limitations of the studies, discussion regarding how the literature is related to nursing, and summarization of the literature which has been reviewed. The literature review will consist of three sections: interinstitutional relocation of the elderly, adaptation and orientation programs.

Interinstitutional Relocation of the Elderly

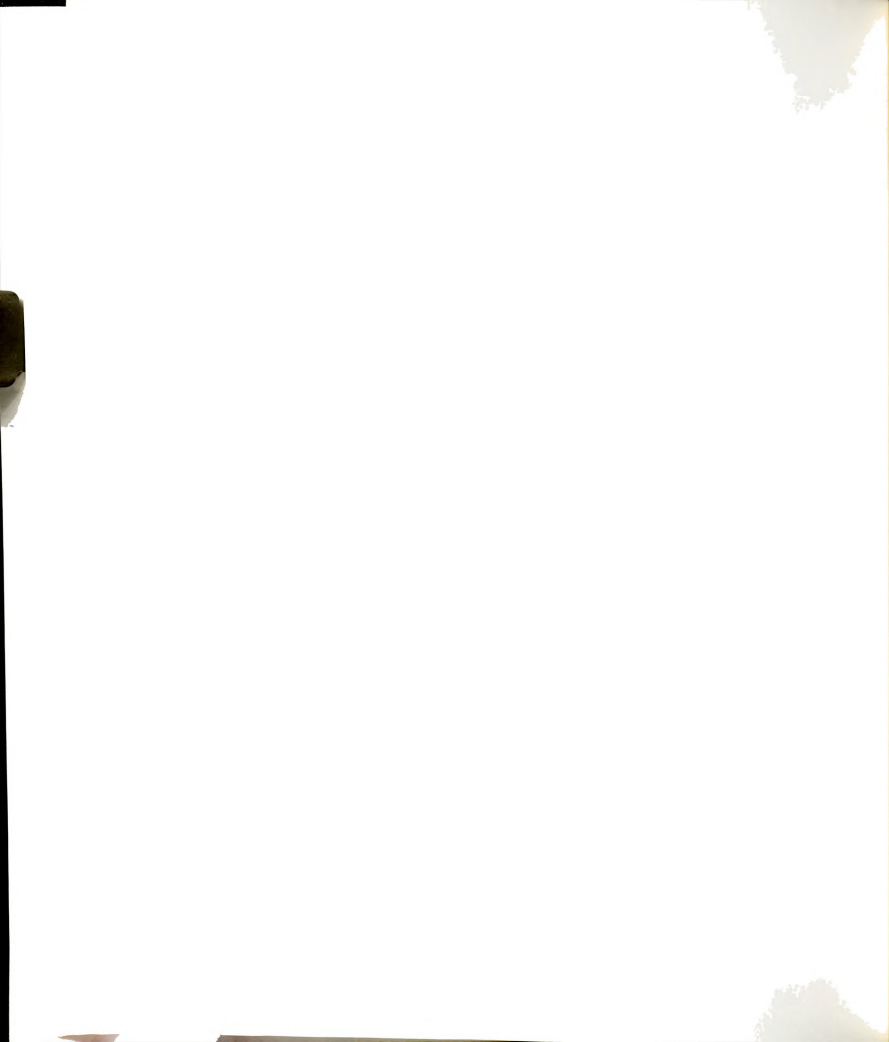
Several studies have been completed regarding the issue of interinstitutional relocation of the elderly. Basically there are two conclusions which have been formulated from the studies which have been completed. The first conclusion indicates that relocation of the elderly to an institution is a negative experience which results in increased morbidity and mortality of elderly individuals (Pastalan & Bourestom, 1977; Thomas, 1979). The second conclusion indicates that interinstitutional relocation of an elderly individual

has little or no effect on the morbidity or mortality of the elderly individual (Borup, Gallego & Heffernan, 1979) and the relocation is not viewed as a negative experience. Due to the discrepancy in the findings of the studies regarding interinstitutional relocation of the elderly, according to Mirotznik and Ruskin (1984) "it is imperative that we continue to expand our knowledge to better understand the consequences of relocation for the elderly" (p. 286).

Effects of Relocation on Mortality Rates

In studying the effects of interinstitutional relocation from the perspective of the effects of the relocation experience on mortality rates, Pastalan and Bourestom (1977) studied two groups of elderly nursing home patients (N = not reported) who were being relocated to different nursing homes. The study was initiated in 1971 and the patients were matched in age, sex, physical and mental health. One group was relocated after four preparatory visits to their new home and the other was moved after only one preparatory visit to their new home. Within one year, 27% of the first group had died and 52% of the latter group had died.

The small study completed by Bourestom and Pastalan (1977) lead Pastalan and a team of researchers in Pennsylvania to study a larger group of elderly individuals who were experiencing interinstitutional relocation from one nursing home to another (N = 400). The study was completed in 1974. The elderly individuals were prepared by the nurses and social workers from their nursing home and were



familiarized with the new environment utilizing counseling sessions, group discussions and visits to the new homes (Pastalan & Bourestom, 1977).

The study group in Pastalan and Bourestom's (1977) study was evaluated at the end of one year and, upon measuring the annual mortality rate of the 400 elderly individuals, the annual mortality rate was measured at 22%. In summarizing Pastalan's (1977) study, the 22% annual mortality rate experienced in the study was compared to the 27% annual mortality rate for elderly individuals in Pennsylvania, and to the national mortality rate of 28% for elderly individuals. Pastalan and Bourestom (1977) established that the 22% annual mortality rate showed an improvement in mortality rate and related the improvement to prior preparation for the move.

Pastalan (1977) and the other researchers established that if an elderly individual was moved more than 45 miles, the mortality rate was higher than for those individuals who were moved a shorter distance. Another conclusion made by Pastalan (1977) and the other researchers was that "those who definitely accepted or rejected the move died at a lower rate than those who did not seem to care" (p. 32).

In reviewing the results of Pastalan's (1977) Pennsylvania study, it is not clear whether or not the mortality rates were truly affected by the relocation experience or if the mortality rates were caused by other factors, such as illness, frailty, stage of disease, or type of diagnosis. However, the pervading message in Pastalan's (1977) program is that preparing the elderly individual prior to the



relocation experience seemingly positively affects the adjustment to the new setting and decreases the mortality rate.

In studying the issue of mortality as related to interinstitutional relocation of the elderly, Butler and Lewis (1983) report that 85-90% of persons who enter nursing homes do not leave them alive. According to Butler and Lewis (1982), the average length of stay is 1.6 years, one-third of the residents die within the first year of relocation to the nursing home, and another one-third die between the first and third years post-relocation.

In 1983, Chenitz completed a qualitative study of two groups of elderly individuals who experienced difficulty in making the transitions to nursing homes upon relocation (N = 30). The individuals were studied from admission to six to nine months after admission and were interviewed several times each week during that time.

Chenitz (1983) used grounded theory methodology and analyzed the data from the actual experiences of those persons who were relocated. The group of elderly individuals studied were compared to a similar group of elderly who were receiving home care (N = 30). Also interviewed were staff, physicians, and other elders in nursing homes in the area, and those subjects were used as a basis for comparison.

The elderly individuals who were experiencing relocation in Chenitz's (1983) study displayed several types of reactions to the move from acceptance to resistance. Resistance was demonstrated by "giving up the will to live" or "just waiting to die" (Chenitz, 1983,

p. 85). Chenitz also explains the relocation process as a "status passage" or a movement from one life experience to another to include moving from life to death. In other words, mortality can be viewed as a result of the relocation process.

Pino et al. (1978) completed an experimental study of elderly individuals (N = 100) who were relocated. The participants were subdivided into four groups of twenty-five participants each: relocated patients, prepared transfers, unprepared transfers and control group. The instruments used for measurement in the study were the Life Satisfaction Scale, the Personality Adjustment Scale, Raven's Progressive Matrices, Activities of Daily Living and the Mental Status Questionnaire. The data was gathered one week prior to transfer to one week after admission and again after nine months.

Analysis of the data included analysis of variance of pre- and post-measurements for the four groups. The results of the measures on the Life Satisfaction Scale were reported as significant differences (at the .005 level) which "demonstrated the superiority of the transferred groups to the relocated control groups on this test" (Pino et al., 1978, p. 170). The results were found to be nonsignificant when testing group differences on the Personality Adjustment Scale and on the Raven's Progressive Matrices (a nonverbal, culture-free IQ test). All groups performed significantly better than the control group on the Activities of Daily Living Scale and on the Mental Status Questionnaire. Therefore, since the "prepared" patients performed at a more successful level, it has been



postulated by the authors that the mortality rates of the prepared groups was lower than the rates of the unprepared group.

A descriptive study investigating the effects of the interinstitutional relocation was completed by Mirotznik and Ruskin (1984) on the health of chronically ill patients (N = 306) and the authors determined that "relocation had no positive or negative effect on 13 of 18 health measures investigated" (p. 286). The instruments which were used in the study were the Albert Einstein College of Medicine Depression Scale (AECMDS) to measure post-relocation morale, a questionnaire measuring patient satisfaction with the move, a medication review instrument and a review of the number of specialist consultations. Data were analyzed and the results of the study indicated that relocation had no effect on 13 of the 18 health measures. "The five measures which exhibited significant main and/or interaction effects were Pulse Intensity, Respiration Frequency, Respiration Intensity, Sedatives and Tranquilizers and Specialist Consultations" (Mirotznik & Ruskin, 1984, p. 288). Four of the five measures were reported by the authors to show positive effects post-relocation and one of the measures was reported to show a negative effect. A negative effect was experienced by elderly patients who exhibited a decrement in health as measured by Specialist Consultations.

Mirotznik and Ruskin (1984) concluded that "the study's findings suggest that several of the factors which mediate mortality during relocation also mediate the impact of relocation on health" (p. 291). The factors which Mirotznik and Ruskin (1984) referred to

as mediating the impact of relocation are: 1) interest and concern by the administration and professional staff of the nursing home; 2) an extensive relocation plan to minimize relocation trauma; 3) formation of an "Interdisciplinary Relocation Team" to provide emotional and social support to the patients; and 4) patient involvement in decision making regarding the move.

According to Horowitz and Schultz (1983) "40 empirical studies have been completed regarding interinstitutional or intrainstitutional relocation of the elderly and 32 of these 40 studies report mortality comparisons" (p. 232). Horowitz and Schultz's article is a critique of the relocation literature regarding interinstitutional and intrainstitutional relocation of the elderly. The authors report that the articles which accept the null hypothesis that relocation has no effect on mortality rate are invalid and unreliable.

Borup (1983) responded to Horowitz and Schultz (1983) and continues to propose that interinstitutional and intrainstitutional relocation has no effect on mortality rates of elderly individuals. Borup (1983) proposes that "we need now to direct our attention to possible adverse conditions that are causal to an individual's vulnerability to mortality when relocating" (p. 241). The possible adverse conditions deal with morbidity.

In reviewing the literature on the issue of the effects of relocation on mortality rates of elderly individuals, Borup's statement regarding the need to direct attention away from the mortality issue is justified. Due to the discrepancies in the findings after each attempt to attribute increases in mortality rates

to relocation effects, it becomes obvious that another method for measuring relocation effect is needed. All of the studies, including the studies of Pastalan and Bourestom, indicate that issues such as preparation for the move, orientation to the new location and allowance for patient involvement in decision-making positively affect the relocation experience. Therefore, it seems more feasible to investigate those more positive issues in studying relocation.

Effects on Morbidity

Pastalan and Bourestom (1977) investigated the effects of relocation of the elderly on mortality rates and several others investigated the effects of relocation of the elderly on morbidity rates. In reviewing the literature regarding the perspective that morbidity rates are affected by relocation of elderly individuals, Thomas (1979) completed a descriptive study of elderly residents in six skilled nursing homes in a three county area (N = 30) focusing upon the morbidity rate post-relocation for the elderly population who was studied. The tools used in the study were the Cornell Medical Index Health Questionnaire (CMI) which was used to elicit medical and psychiatric information and the Geriatric Social Readjustment Rating Scale (GSRRS). The GSRRS measured the amount of stress undergone by the patient within the past five years (Thomas, 1979). Also utilized was the Signs and Symptoms of Stress Checklist (SOS) which is Thomas' own instrument. The data analysis was completed by classification of symptoms by body systems to identify

morbidity patterns and trends. The Spearman rank order correlation coefficient was used to analyze the data (Thomas, 1979, p. 267).

The elderly subjects in Thomas' (1979) study were observed for 28 days and the results from the CMI indicated that 41% of the relocated elderly were reported to be angry and 27% were depressed. The physical symptoms reported in order of frequency were: 1) cardiovascular system problems; 2) digestive system problems; 3) confusion; 4) sleeplessness; 5) fatigue; 6) crying; and 7) feelings of hopelessness (Thomas, 1979, p. 267). Every subject reported significant emotional disturbance according to the GSRRS.

Thomas (1979) concludes that relocation affects morbidity but cites the limitations of her study as "a small population, insufficiently trained data collectors, a short observation period and the need for modification of the data collection tools" (p. 271). As in Pastalan's (1977) study, it is difficult to state that the reason for the change in morbidity rate was due to the effects of relocation only. Several other factors such as type of diagnosis frailty and mental status could affect the results of the study.

In relationship to morbidity as related to relocation of the elderly, Rodstein et al (1976) completed a descriptive study of elderly individuals admitted to the Jewish Home and Hospital for Aged (N = 100). The participants were studied for one month post-relocation. The physical health factors and behavioral changes were analyzed independently and then correlated. Fifty subjects did not show any significant changes in medical status, 14 had minor changes, 15 had moderate changes and 21 had severe changes in medical status.



The majority of the changes which were significant in relationship to medical status were cardiovascular changes. After six months the medical status changes were re-evaluated and 25% of the patients with moderate or severe medical changes showed improvement or complete resolution of the changes.

Fifty subjects in the study by Rodstein et al. (1976) showed significant difficulties in adjustment as measured by evaluation of the quality of adjustment. The quality of the adjustment was measured in terms of mood, anxiety, orientation, personality characteristics, interaction with staff and residents and family relations.

The conclusion which was drawn by Rodstein et al. (1976) in regard to morbidity rates as related to relocation was that the initial period post-relocation is a stressful experience. However, among those elderly who manifested problems of adjustment, the majority improved within six months after admission.

In reviewing the literature regarding the effects of relocation, it is initially a stressful experience which has some negative effects on physical health. However, after one to six months when the relocated elderly are re-evaluated, there is improvement in the individual's physical health. Therefore, effects of relocation on morbidity are short-lived.



Lack of Effect on Morbidity/Mortality

The improvement in adaptation after a longer term of adjustment indicates that the effects of relocation on morbidity and mortality are not as significant as appearances indicate. Borup et al. (1979) studied the effects of interinstitutional relocation on mortality of elderly individuals (N = 982) and determined that relocation had no effect on mortality. Borup et al. (1979) studied 30 nursing homes in Utah. An experimental-control research design was utilized. The experimental group consisted of all patients residing in 30 nursing homes and the control group consisted of all patients residing in 19 randomly selected homes. Both groups were contacted during the course of the study. The experimental group was contacted on four occasions and the control group was contacted on two occasions.

The mortality rates were calculated for the two groups, and data were analyzed using the Chi square technique. The findings of the study indicated that the mortality rates for those patients in the experimental group were lower than for those in the control group. Further analysis of data indicated that the control group contained more old-old patients, and the difference in the mortality rates in the two groups was apparently due to the large number of old-old patients in the control group, not due to relocation effects. Therefore, Borup et al. (1979) concluded that relocation has no influence on mortality of elderly individuals who are relocated.

Engle (1985) completed a descriptive study of elderly individuals who were relocated from a hospital to a nursing home (N = 55). The participants were 60 years old and older and were evaluated for level

of consciousness, attention, concentration, orientation, memory, and higher cognitive function using the Mental Status Examination. Six activities of daily living were also evaluated using the Scaled Outcome Criteria.

Data were collected over a four day period and data were analyzed using a matched pairs t-test which demonstrated no significant differences in the mean scores of the participants' functional status over the four day period. There was no significant difference between Day 1 and Day 4 for level of consciousness, attention/concentration, orientation or higher cognitive function (Engle, 1985). However, a significant finding was reported regarding memory. There was significant improvement in memory, both short- and long-term from Day 1 to Day 4. No deterioration in functional or mental status was determined in Engle's study. The study results were reported to demonstrate either no change or slight improvement in status. Therefore, the findings in Engle's study are reported indicating that interinstitutional relocation of the elderly has no effect on morbidity or mortality.

Nirenberg (1983) completed an experimental study of cognitively low-functioning and high-functioning subjects (N = 40) who experienced interinstitutional relocation from an old, deteriorating facility to a new facility. Nirenberg tested the participants two weeks prior to relocation, three weeks following relocation and three months post-relocation. The instruments utilized in the assessment of the elderly were the Short Portable Mental Status Questionnaire, the Philadelphia Geriatric Center Morale Scale, the Physical

Self-Maintenance Scale, the Face-Hand Test, and the VIRO Assessment Scale. The treatment of the participants involved a basic relocation preparatory program which involved all subjects. One-half of the low-functioning group was assigned to a behavioral skills program and one-half of the high-functioning group was assigned to a cognitive skills program. The control groups consisted of one-half of the low-functioning and one-half of the high-functioning groups and were visited by volunteers on the same days that the treatment groups received training.

Nirenberg (1983) analyzed data from the study utilizing the techniques of multivariate analysis of variance (MANOVA) and Post hoc Scheffe' means comparisons. The results indicated the "the behavioral skills program led to favorable post-relocation changes, but the cognitive skills program did not" (p. 693). Overall, the experiment showed that the relocation experience had no effect on the morbidity or mortality rates of the individuals studied. The results indicated differences in adjustment or adaptation as evidenced by an increase in passive-withdrawn behaviors in low-functioning subjects and an increase in active-outgoing behavior in high-functioning subjects.

Stein, Lynn and Stein (1985) reported a descriptive study of elderly individuals who were newly admitted to ten nursing homes (N = 223). The study took place over a two and one-half year period and "the purpose of the study was to explore the dimensions of anticipated stresses of institutionalization in a newly admitted group of nursing home residents, and to determine the relationship of



these anticipated problems to demographic and attitudinal variables as well as to psychological and physical function" (p. 89).

The instruments used in Stein's (1985) study were a 20-item Stresses in Institutional Care Scale (SIC), a five-point scale to measure attitudinal variables, Rotter's Scale, the POMS, Sherwood's Self-Esteem Scale and the Rapid Disability Rating Scale. Data were analyzed utilizing correlations and factor analysis. The results from the SIC scale indicated that identifying stresses which the elderly experience related to relocation to a nursing home provides the staff with information regarding the patient's specific concerns. The identification of the stressors which are defined by the patient (severance anxiety, medical concerns, tender loving care, relocation, orientation and individual space) allows the staff the opportunity to address the patient's concerns. Addressing the patient's concerns lessens the stress and improves the outcome of the relocation experience. Therefore, relocation of the elderly when accomplished in this manner does not negatively affect morbidity and mortality rates.

Summary Morbidity/Mortality

In reviewing the literature regarding the issue of the effect of interinstitutional relocation on the morbidity and mortality rates of elderly individuals, it is indicated by the findings that there is disagreement regarding this issue. The authors of the research studies regarding interinstitutional relocation of the elderly conclude either that: 1) morbidity and mortality rates are

negatively affected by the move; or 2) there is no effect on morbidity and mortality rates post-move. Therefore, the focus in this study does not deal with the issues of mortality and morbidity but deals with the broader issue of whether or not the elderly can effectively adapt upon relocation from one institution to another.

Adaptation

Adaptation is defined as "anything that is changed or changes so as to become suitable to a new or special use or situation" (Morris, 1973, p. 14). According to Roy (1981) adaptation is defined as "the person's reponse to the environment which promotes the general goals of the person including survival, growth, reproduction and mastery" (p. 53). McGlynn (1983) reports that adaptation is "the way a person responds to focal, background or internal stimuli if the behavior remains constant" (p. 32). For the purposes of this study adaptation is viewed in terms of an outcome which is expressed as "more positive adaptation." "More positive adaptation" for the purposes of this study is defined as certain, accepted or affirmed change which is accomplished so as to become suitable to a new situation. The concept "more positive adaptation" is defined as a positive change for the individual post-relocation, whereas morbidity and mortality denote a negative change for the individual as a result of the relocation experience.

Farkas (1981) completed an experimental study "to identify adaptation problems on the part of elderly persons and significant others that were associated with nursing home applications for



elderly persons in Canada" (p. 363). The group studied (N = 44) included both elderly individuals applying to nursing homes, their families and significant others and a control group. The conceptual framework for the study was based on the Roy Adaptation Model (Farkas, 1981).

Farkas (1981) utilized "face-to-face interviews" in the elderly subjects' homes to collect data. "Scales for powerlessness as well as knowledge and utilization of services were developed" (p. 364). Data were analyzed utilizing Chi square technique.

Farkas (1981) indicated that the original reason for a nursing home referral is a problem of adaptation in the physiological mode. However, the problems of adaptation in the physiological mode were viewed by the patients' significant others as within the coping capabilities of the elderly subjects. The significant others' concerns regarding problems of adaptation dealt more specifically with the self-concept and role function modes. The specific adaptation problems which the elderly individuals experienced were specific to the interdependence and the physiological modes of Roy's Model. Therefore, the elderly in Farkas' study viewed dependency and physiological problems, i.e., hearing loss, incontinence, difficulty climbing stairs as a greater problem than the issues of self-concept and role function.

The significant others in Farkas' (1981) study felt that the physiological problems as well as the issue of dependency could be overcome. The significant others viewed the issue of the elderly's concept of his/her capabilities and self-concept as well as the

elderly's role function as the areas of greatest concern regarding adaptation to the need for nursing home placement. The difference in the feelings of the significant others as compared to the feelings of the elderly regarding the adaptation problems in considering the need for a nursing home admission play a significant role in how well the elderly person adapts.

Craig (1983) developed a conceptual model for adaptation in chronic illness. Craig (1983) defined adaptation as "coming to terms with the reality of chronic illness as a stage of being, discarding false hope and destructive hopelessness, and restructuring the environment in which one now functions" (p. 399). Craig's framework could easily be applied to adaptation to any major life change such as relocation.

Craig (1983) describes adaptation as the goal or outcome to the event of chronic illness which is accomplished through utilization of the process of appraisal and reappraisal. The process of appraisal-reappraisal consists of problem-solving techniques and coping. Craig's framework purports that through utilization of problem-solving and coping techniques, the person eventually adapts.

Janelli (1980) reports the use of Roy's Adaptation Model in gerontology, especially when dealing with the elderly when they are facing life transitions or changes. According to Janelli, "change is seen as an adaptive process" (p. 140) involving interactions among psychological and biological elements.

In discussing Roy's Model of adaptation, Janelli (1980) reports that "the dynamic force of the model rests in man's ability to adapt

to an ever-changing environment" (p. 140). Janelli discusses the application of Roy's Model to hypothetical elderly patient situations to emphasize the point that the elderly's needs in any situation can be met by viewing them as adaptive individuals. Janelli points out that because of the elderly's state of developmental process, they are experiencing major changes rapidly and must learn to adapt in order to survive.

Chenitz (1983) views nursing home admission as a crisis for the elderly individual and states "if the crisis is not resolved, the elder continues to function maladaptively" (p. 97). Chenitz studied elderly individuals who were admitted to two nursing homes in the San Francisco Bay area (N = 30) and compared their experiences to a group of elderly individuals receiving home care from visiting nurses (N = 30) in a qualitative study. Chenitz reported that the elderly individuals' reactions to relocation resulted in various displays of behavior from acceptance to resistance, and that the elderly view the relocation experience as one of the many passages which an individual experiences during life.

Moos, David, Lemke, and Postle (1984) studied elderly individuals in an older nursing home who were relocated to a new building (N = 98) and examined behavioral patterns of residents and staff who were involved in the move. The study was descriptive and the measurement instrument which helped describe the changes post-relocation was the Multiphasic Environmental Assessment Procedure (MEAP). The MEAP assessed the facility's physical features, policies and programs, resident and staff characteristics and social climate.

Data in Moos' et al. (1984) study was analyzed utilizing percentages and analysis of variance techniques. The result of the findings was that the residents utilized the new building living space differently than they had utilized space in the old structure i.e., spending more time in the halls of the new structure and less time in lounge areas. These types of behavioral changes were "conceptualized as attempts to adapt to the larger design and altered layout of the new facility" (p. 495). According to Moos' et al. study, the elderly who are faced with the experience of relocation experience adaptation as measured by behavioral changes i.e., passive behavior, active task-oriented behavior, and interpersonal and social behavior as a result or outcome of the move. Interactions between residents and staff increased post-move as well as interactions with individuals from outside the facility. Also, the residents' participation in organized activities at the institution increased dramatically from before the move to two months post-move (Moos et al., 1984).

King et al. (1987) completed a descriptive study of 37 relocated elders who were forced to move from a small rural mining town in Utah to other communities. The subjects were interviewed and categorized according to how well they adjusted to the move. Presence of a confidant, self-esteem, the amount people worry, and perceived health were all cited as factors relative to type of outcome post-move.

King et al. (1987) concluded that the risk of relocation trauma must be assessed and concern and support by professionals are important to the client. Another conclusion of King et al. is that

the relocation experience and the outcomes are individualized experiences and "nurses can use a continuum of care to develop interventions that match the individual needs of relocating clients" (p. 261)

Summary - Adaptation

In reviewing the literature, adaptation is viewed as a method by which the elderly deal with change. A great deal of the literature regarding the concept of adaptation discusses the concept of coping. It is imperative, however, that the concepts are clearly defined and that they are not used interchangeably. Coping and adaptation are very different concepts.

Coping is defined as a process and adaptation is defined as an outcome. According to Roy (1981), coping is the process which the individual internalizes in the cognator/regulator process subsystems and the response to or outcome of the coping process is positive or negative adaptation. Adaptation can be measured in terms of outcomes which can be identified by the professional nurse during his/her assessment of an individual.

Adaptation is the concept which has been selected as the method by which the elderly deal with change. Adaptation is viewed as an outcome and the processes of coping, adjustment and problem-solving are utilized as means to accomplishing the outcome of adaptation.

In order to accomplish positive adaptation, for the purposes of this study, an orientation program was introduced. The orientation



program positively affected the adaptation experience of the individual.

The outcome of adaptation was to be measured by the elderly individual's performance on a test of knowledge about the nursing home pre- and post-orientation and the level of socialization 30 days post-admission was to be measured by review of social activity attendance records, staff perception of socialization and the social worker's perception of his/her socialization. High levels of performance on the knowledge examination as well as a high level of socialization were to be indicators of positive adaptation to the nursing home.

Knowledge

The concept of knowledge was to be measured in this study as a determinant of the amount of adaptation experienced by the elderly individuals. Knowledge has been measured in the relocation literature (Amenta et al., 1984; Engle, 1985; Nirenberg, 1983; Pino et al., 1978) as an indicator of successful adaptation. Knowledge is generally measured in relationship to the change in knowledge level after prior preparation for the move. Knowledge levels are higher for those elderly individuals who are prepared prior to the move as compared to those individuals who are not prepared for the move.

Socialization

In addition to improving knowledge with prior preparation for the move, social activity status is also improved with prior preparation for the move (Engle, 1985; Grey, 1978; Moos et al., 1984; Nirenberg, 1983). Social activity is measured as the amount of social

interaction which is exhibited by the elderly individual post-relocation. For the purposes of this study, the provision of the orientation program to the extended care facility by the registered nurse was to be the stimulus which affected the amount of social activity which is exhibited by the elderly individual post-relocation. However, social activity is an individualized type of experience in which the amount of social activity which is exhibited prior to institutionalization, must be taken into consideration when evaluating the individual's social behavior post-institutionalization.

Orientation Program

In looking more closely at the issue of relocation involving elderly individuals who are moving to institutions, researchers in relocation have been able to agree upon one issue: Prior preparation for the move positively affects the elderly individual's adaptation to the move (Borup, Gallego, & Heffernan, 1979; Burnside, 1981; Ebersole & Hess, 1981; Giorella & Bevil, 1985; Hunt & Roll, 1987; Nirenberg, 1983; Pastalan & Bourestom, 1977; Wolanin, 1978; Yurick, Robb, Spier & Ebert, 1984). Despite the difference in opinion in the literature regarding the effect or lack of effect of relocation on morbidity and mortality rates, the issue of prior preparation for the move as a factor in the elderly person's positive adjustment to an institution is supported in the literature.

One method of preparing an elderly individual prior to relocation is by providing an orientation program for the individual. Several

studies have been completed which have incorporated an orientation program prior to or at the time of the move. Kennedy et al. (1987) reported effective comprehensive discharge planning as one method of prior preparation to moving the elderly from the acute care setting. In an experimental study of 80 elderly, acute care patients, Kennedy et al. report that for those in the treatment group, "length of hospital stay was reduced by two days and the average time between discharge and readmission was increased by 11 days utilizing comprehensive discharge planning."

Hunt and Roll (1987) reported environmental simulation as an effective technique in preparing the elderly individual for a move to an unknown building. In a field experiment of 60 elderly individuals, there were three evenly divided groups of participants: site visit group (20); simulation group (20); and control group (20). The findings were indicative that environmental simulation is comparable to site visits in instilling confidence and improving efficiency in way-finding in the new setting. In other words, prior preparation to the move is beneficial in assisting elderly individuals in their adaptation to the new surroundings.

Pino, Rosica and Carter (1978) completed a study regarding the differential effects of relocation on nursing home patients with the hypothesis that the patients who are relocated from another institution "will have more difficulty in readjusting than the transferred patient who has been prepared for the move, or the unprepared transferred patient" (p. 167). (Transferred is defined as an intrainstitutional move.) The patients in this study were divided

into four groups: "relocated patients, prepared transfers, unprepared transfers and the control group. (A stationary group of aged patients at a neighboring institution within the same geographical area.) (p. 167). As in the the study by Nirenberg (1983), a battery of tests were used to assess the patients' psychological status and to assess "their reported sensitivity to change" (Pino, Rosica, & Carter, 1978, p. 169).

The result of the study by Pino, Rosica and Carter (1978) showed that "prepared patients demonstrated less decline in mental alertness than other groups, but only slightly less than the unprepared transfers; the relocated subjects declined slightly less than the unprepared transfers; and the relocated subjects declined significantly in Life Satisfaction and Personality Adjustments" (p. 172). The recommendations made after completion of the study include: 1) extensive preparation for relocation should focus on the positive aspects of the new environment; and 2) an assessment measure should be administered prior to the move to help identify the patients most susceptible to relocation trauma.

Grey (1978) completed a study of residents of the Jewish Home for the Aged in New Haven (N = 137) who were moved from an old building to a new building. The planning for the move was initiated one year previous to the move. A "move committee" was formed and the task for the committee was to accomplish proper placement of patients. A written plan for the move was completed for each department. The plan was very detailed and well-organized.

The orientation program involved nine months of staff orientation including informal discussions, development of the concept of team nursing, involvement in patient placement and formal tours of the new facility to include new equipment and systems review. The patient orientation was directed by the Recreation Department. Four weeks were allotted for orientation of patients (Grey, 1978).

Patient orientation included visitation of their new rooms, if possible, involvement in decisions regarding the move, casual talks and discussions, distribution of drawings of the new facility and formal discussions by administrative staff regarding the move (Grey, 1978). The patients' orientation generally was accomplished utilizing small group sessions.

In Grey's (1978) study, the families and volunteers were also prepared for the move. Therefore, both volunteers and family members assisted with and participated in the move.

The post-move changes as a result of the study showed "comparison of the patient profiles prior to the move and the post-move profiles done 90 days after the move" (Grey, 1978, p. 36-37). The results indicated that 59 residents actually showed an improved status post-move and the mortality rates for the patients post-move were at a "remarkably low rate" (p. 37). When speaking of improved status, Grey indicated that the patients showed an improvement in incontinence, locomotion and/or behavior as measured by a comparison of the profiles of patients pre- and post-move.

According to Grey (1978), by providing an orientation program prior to the move, the indication is for "successful moves with less



mortality" (p. 38). Also, the orientation program provided a means by which, through involvement in decision making, the elderly may play an important role in the relocation event.

Amenta, Weiner and Amenta (1984) studied a 97-year old private nursing home which was closing. The residents (N = 47) of the nursing home were relocated to a neighboring facility. The length of stay of the residents being moved was one year to 25 years at the old facility.

According to Amenta, Weiner and Amenta (1984), "to reduce the trauma of relocation as much as possible, an extensive preparation program for these people and their families was begun seven months before the move" (p. 356). The residents were all notified of the move on the same day by letter.

The preparation program consisted of: 1) a film-strip about the new location three weeks after initial notification; 2) visits by the new facility's staff; 3) inventories of patients' personal possessions; 4) visits from a program director from the new facility on a one-to-one basis to every resident; and 5) exploration of the issue of compatible roommates (Amenta et al., 1984).

Within the new facility were two groups: one group who agreed to move to accommodate the incoming group from the old facility which was closing and one group who chose not to move. Thus, the study included observation of three groups who were involved differently in the relocation experience. Those patients moving to the new facility from the old nursing home and the two groups within the new facility.



The measurement tools which were utilized by Amenta et al. (1984) were: 1) an assessment form incorporating "the five goals of long-term care distinguished by Bloom: physical, mental, affective and interpersonal functioning; and influence on the social environment (p. 358); 2) the NOSIE scale which tested for affective function; 3) the Geriatric Rating Scale of Plutchick et al.; 4) the ADL Scale of Katz. The residents were assessed and then reassessed at intervals of one, three, eight and 12 weeks and at six months (Amenta et al., 1984).

The scores on the measurements were analyzed for change in general condition and for differences in decline between groups. Significant differences were noted in which the stationary group performed less well on all measures of general condition and fine symptom scores than did the relocated group. However, the relocated group fared less well than the transferred group on the same measures.

According to Amenta et al. (1984), although the findings were not as dramatic as the authors had anticipated, the groups which were prepared for relocation (the relocated and the transferred groups) fared better due to the prior preparation for the move. The relocation group basically viewed the move as a positive experience and the transferred group enjoyed being hosts to the newly relocated group. The stationary group had no preparation for or participation in the move and fared least well.

Livy (1979) addresses the issue of "admission trauma" when a patient is admitted to a nursing home. Livy discusses a program to



provide for "more humanized admission procedures" (p. 11) entitled "Social Adjustment Program." The goals of the program are to:

- "1. Reduce admission and transfer trauma.
2. Increase patient and family involvement in the admission and transfer procedures.
3. Provide a smoother transition between injury or illness and recovery.
4. Humanize admission and transfer procedures.
5. Improve community relations.
6. Increase patient screening.
7. Build rapport between patients, family and health care facility.
8. Make staff more aware of patients' needs" (p. 11).

The "Social Adjustment Program" involves three parts (Livy, 1979). Part I involves visiting the patient in the hospital and orienting him/her to the facility. Part II involves visitation by the nursing staff, therapists and social worker, ordering of all personal services and initiation of the interdisciplinary plan of care. Part III involves a welcome by a member of a committee of alert patients who invites the patient to activities, meals and a tour of the facility. Livy proposes the "Social Adjustment Program" a type of orientation program, as "a possible solution to admission trauma" (p. 10).

Palestis (1986) proposes that "the admission ward concept" is a type of orientation program for elderly individuals who are newly admitted to a nursing home. The Admission Ward is a 25-bed unit where the new patients are admitted and a comprehensive assessment is

completed. The assessment involves a physical and social assessment as well as a determination of the patient's ability to accomplish activities of daily living. The assessment is accomplished by an interdisciplinary team of health care professionals. "The average length of stay on the Admission Ward is three to four weeks" (Palestis, 1986, p. 40). The patient is then moved to a "home unit where he/she will remain unless there is a significant change in status and a need for a different type of care" (p. 40).

Palestis (1986) reports that "The Admission Ward concept reduces the incidence of inappropriate assignment of residents and, thus, reduces the frequency of interunit transfers" (p. 41). The concept of an Admission Ward also allows the patient time to become oriented to his/her new role of nursing home resident.

Petrou and Obenchain (1987) completed a study of 101 patients who were relocated to a newly constructed 120-bed nursing home care unit (NHCU) to determine "to what extent planned nursing interventions prior to relocation reduced physical health problems after patients were transferred to the new unit" (p. 264). The findings which were reported by Petrou and Obenchain were that the prepared group in this experimental study "experienced fewer incidents of negative health indicators than the group who were admitted to the nursing home without any known preparation" (p. 266).



Summary - Orientation Program

It is evident by the numerous reports in the relocation literature that prior preparation for the move or orientation programs are an integral component for a positive relocation experience for an elderly individual who is being admitted to a nursing home. There is a discrepancy in the literature regarding the effects of relocation on mortality and morbidity in the elderly, but the authors of relocation literature generally agree that prior preparation for the move positively impacts the relocation experience.

Relationship of Literature to Nursing

It is apparent in the relocation literature that the more positive the relocation experience for the elderly individual when moving to a nursing home, the better the chances for the elderly individual to adapt to the new location. The relationship of a positive adaptation by an elderly individual to a nursing home to nursing is that the professional nurse is capable of affecting the patient's relocation experience by:

1. Providing prior preparation for the move.
2. Providing an orientation program for the individual.
3. Providing support to the family and patient.
4. Answering the patient's and family's questions.
5. Introducing the patient to other patients and to the staff.

According to Weiner (1978) the professional nurse should play an integral role in orienting the elderly patient to the nursing home.

Weiner (1978) reports that the nurse should "listen to the patients" (p. 5) and prepare them with an orientation program which builds trust in the patient as he/she can see that the nursing home staff are caring people.

In applying the findings in the literature regarding interinstitutional relocation, adaptation and orientation programs to the role of the professional nurse, the professional nurse should consider three areas. The professional nurse should assess the effects of the relocation experience on the elderly individual, taking into consideration any effects regarding morbidity and mortality rates. The professional nurse should also consider presentation of an orientation program as an integral component of the relocation experience for all elderly individuals who are experiencing interinstitutional relocation.

Summary of Literature

The implications for the professional nurse dealing with patients who are experiencing interinstitutional relocation are enumerated as implications for: 1) assessment of the interinstitutional relocation experience; 2) identification of the types of adaptation; and 3) the necessity of orientation programs. In reviewing the relocation literature the themes of the nursing implications as identified are favorably supported.

Since the literature favorably supports the concepts of interinstitutional relocation, adaptation and orientation programs as major concepts related to interinstitutional relocation of the



elderly, it is imperative that these concepts are examined more closely. From a nursing perspective, the concepts can be examined more closely to demonstrate the relationship of the effectiveness of the professional nurse's role to the relocation experience of the elderly individual.

Therefore, after review of the literature it has been determined that the relationship between the interinstitutional relocation of the elderly individual and the type of adaptation experienced by the individual is determined by the presence or lack of preparation for the move, i.e., an orientation program. In this study the relationship of the concepts will be addressed as a directional hypothesis which states that an elderly individual from an acute care setting who is provided an orientation program to an extended care facility will experience more positive adaptation than an elderly individual from an acute care setting who is not provided an orientation program by a registered nurse from that facility.

In reviewing the relocation literature there is clearly a discrepancy in opinion regarding the effects of the interinstitutional relocation experience on the morbidity and mortality rates of elderly individuals. Also, there is a great deal of support regarding prior preparation for the move and the use of orientation programs. Therefore, Borup (1983) states "guidelines should now be incorporated that will promote the transfer of patients with the greatest possible care and sensitivity" (p. 24). In other words, it is time to cease arguing about whether or not it can be proven that more people die as a result of interinstitutional relocation than would normally die,



and it is time to look at programs which will improve the quality of the relocation experience for the elderly individual. One program which has the potential to effect a more positive interinstitutional relocation experience for the elderly is proposed in this study.

CHAPTER IV

Methodology and Procedure

Overview

The purpose of this chapter is to present the methodology which was utilized and the procedures which were instituted in order to accomplish a study involving the effects of relocation on the elderly individual who is transferring from the acute care setting to an extended care facility. The content of this chapter includes: the design of the study, population studied, the subjects who were selected and the sampling technique which was utilized. Included also are: 1) operational definitions of the concepts and variables in the study; 2) the instruments which were used; 3) the data collection procedures and analysis techniques; 4) scoring of the measures; 5) a statement about Protection of Human Rights; and 6) reliability and validity of the measurement instruments.

Design

Experimental/Quasi-Experimental

The design which was utilized in this study was the quasi-experimental type of research design. The experimental design was to be utilized in observing the effects of the orientation program by the registered nurse on the knowledge level of the patient at the extended care facility post-relocation. The quasi-experimental design was to be utilized to observe the effects of the orientation



program by the registered nurse on the amount of socialization post-relocation.

The experimental design is characterized by the following properties (Polit & Hungler, 1983, p. 142):

1. Manipulation. The experimenter does something to at least some of the subjects in the study.
2. Control. The experimenter introduces one or more controls over the experimental situation, including the use of a control or comparison group.
3. Randomization. The experimenter assigns subjects to a control or experimental group on a random basis."

For the purposes of this study, the experiment was designed to consist of:

1. Manipulation. The registered nurse will provide an orientation program to one-half of the subjects.
2. Control. The researcher will assign one-half of the subjects to a control group which will not participate in the orientation program which is provided by the registered nurse. The control group will receive the usual treatment which is afforded a newly admitted patient in the extended care facility.
3. Randomization. The researcher will assign all subjects to a control or experimental group.

The quasi-experimental design was designed for comparison of the subject's knowledge pretest to posttest. The experimental design was designed for comparison of experimental and control group differences related to knowledge level.



In utilizing the experimental design, the study participants were to be pretested for knowledge after randomization utilizing a short questionnaire which tests the knowledge level of each participant regarding the policies and procedures of the extended care facility. After the pretest had been completed by a trained volunteer, the orientation program was introduced to the experimental group by the registered nurse. One month after admission to the extended care facility, the knowledge questionnaire was to be readministered by the volunteer as a posttest. The scores on the questionnaire were to be analyzed and compared.

Also, at one month post-admission the social activity records of each participant were to be reviewed, and the staff's and social worker's perception of socialization were to be reviewed. Differences in socialization between the experimental and control groups were to be noted. The amount of socialization of both groups would be analyzed.

The posttest design, which is a type of quasi-experimental design, was to be utilized when examining the subjects' level of socialization. The social activity of the study participants was to be measured at posttest only to determine differences in level of socialization between the experimental and control groups. Since all study participants were newly admitted to the extended care facility, the level of socialization at the time of pretest for all participants was fairly low. Therefore, measuring socialization at posttest retrospectively would allow for examination of differences in amount of socialization experienced by each group over a one month period.



Threats to Internal Validity

The threats to internal validity in this study were the following:

1. Maturation. Participants in this study would adapt somewhat after staying one month at the extended care facility with or without the intervention of an orientation program.
2. Testing. The participants in this study were to be tested and then retested utilizing the same instruments after only a one-month duration. Therefore, the participants could remember the questions and/or their responses.
3. Mortality. There was a potential for attrition of participants in this study due to loss of interest, illness, death, etc.
4. Spill over of information. The participants in the experimental group in this study could potentially inform the participants in the control group about the information which they had obtained in the orientation program.

In order to determine the occurrence or presence of extraneous variables which may affect the participants' adaptation to the extended care facility in this study, a chart review was completed after the posttests were finished. The chart review was accomplished after obtaining permission on the individual consent forms from the participant and/or responsible party. The researcher utilized standardized chart audit forms to obtain information from each medical record related to: physical changes/events, social changes/events, presence of chronic illness(es), physical disabilities, assistive devices used, speech/communication patterns and occurrence

of death post-relocation. The chart audit was completed on all study participants. Charts were reviewed by two auditors; the first person to audit the charts was a reviewer who is a trained volunteer in a profession other than nursing and the second person to audit the charts was the researcher. The charts were reviewed at two intervals not more than two weeks apart. One-half of the charts were reviewed at the first audit period and the other one-half of the charts were reviewed at the second interval. The reviewers audited the charts at different times with the trained volunteer reviewing the charts first. The researcher reviewed the same charts within one week of the student's review.

Population, Subjects, Sampling Technique

The population which was selected for the study of relocation of the elderly from the acute care setting to the extended care facility was those elderly individuals (55 years and older) who were admitted to the extended care facility for the first time. The individuals included in the study had not experienced a previous nursing home admission.

The study participants were selected from all new admissions to the nursing home and were screened utilizing the sociodemographic questionnaire and assigned to either the experimental group or the control group. The subjects who were included in the study met the following criteria.



The subjects:

1. were transferred from the acute care setting to the extended care facility.
2. had experienced no previous admissions to an extended care facility.
3. planned to stay at the facility for at least one month.
4. if diagnosed as having dementia, Alzheimer's disease or organic brain syndrome were unable to respond to the screening items on the Sociodemographic questionnaire.
5. were able to speak, understand, read and write English.
6. were capable of answering questions coherently.
7. were 55 years of age or older.
8. voluntarily agreed to participate and cooperate in the study and were willing to participate upon request in a brief orientation program to introduce him/her to the facility.
9. were able to communicate his/her responses to the researcher if he/she was aphasic, blind or hearing impaired.
10. were mobile so that they were able to complete the tour of the facility (ambulatory, wheelchair bound).
11. identified a family member/significant other who was responsible for their care.

The subjects in the study were required to meet the study criteria and were assigned to the study from the population of individuals who were being transferred from the acute care setting to the extended care facility for the first time. The subjects were screened from the sample utilizing a sociodemographic instrument as a



screening tool (see Appendix A). The sociodemographic questionnaire was given to the participant in interview format by the researcher.

The items on the sociodemographic questionnaire which which were utilized for screening purposes were:

1. Age and birthdate.
2. Languages spoken.
3. Medical diagnosis.
4. Expected length of stay.
5. Number of prior nursing home admissions.
6. Whether the participant had a tour of the nursing home.

All other items on the sociodemographic questionnaire were designed to be exploratory in nature.

The study participants had to be able to answer the items on the sociodemographic questionnaire related to age/birthdate, languages spoken, number of prior nursing home admissions and whether the participant had a tour of the nursing home for purposes of screening for mental awareness. If the participants were unable to respond to the screening items, they were considered ineligible for the study. As many of the participants who were transferred from the acute care setting were acutely ill and/or were experiencing a decrease in mental status, it was anticipated that the percentage of participants who were unable to answer the screening items on the sociodemographic questionnaire would be higher than for previous admissions.

Sampling

The sampling technique which was selected for use in this study was an accidental sampling or sample of convenience. Convenience

sampling was a nonprobability sampling method (Polit & Hungler, 1983). The participants were selected from those individuals who were newly admitted to the extended care facility.

Assignment to Experimental/Control Group

The individuals who participated in the study met the criteria of the study and identification numbers were assigned to the selected participants. Starting with the first admission upon the onset of data collection, the admissions were numbered in order of admittance, starting with number one. The odd numbered participants were assigned to the control group and the even numbered participants were assigned to the experimental group.

Operational Definition of Major Concepts

One of the major concepts in this study was the concept of the orientation program. The other major concepts included interinstitutional relocation and elderly adaptation. The major concepts in this study have been conceptually defined in the discussion regarding the conceptual framework, however, the concepts require operationalization in order to describe how they were utilized specifically in this study.

The orientation program was conceptually defined as "a plan of procedure to assist a person in an adjustment or adaptation to a new environment or situation." The orientation program was operationally defined as a program presented by a registered nurse to introduce the experimental group participants to the extended care facility within 48 hours of admission. The orientation program consisted of:

1. An introduction to the facility's policies and procedures regarding: 1) the Patient Bill of Rights; 2) times of daily routines (meals, medications, bedtime activities); 3) activities and services which are available (recreational activities, therapies, beauty/barber shop, library, consultants, i.e., podiatrist, dentist, psychiatrist); 4) visiting hours; and 5) ancillary services (laundry, maintenance, dietary, housekeeping).
2. A tour of the facility.
3. Answering any questions which the patient may have regarding the facility.

The orientation program consisted of a comprehensive introduction to the facility utilizing a brochure containing the Patient Bill of Rights and a handout identifying the times of the daily routines, the activities and services which were available, the visiting hours, and the ancillary services which were provided by the facility. Also included in the program was a tour of the facility. The orientation program was administered by the researcher and was initiated by the researcher within 48 hours of admission to the facility. The orientation program was administered at one sitting on a one-to-one basis with each participant in the patient's room or in the lounge area.

The tour of the facility was also given by the researcher within 48 hours of admission. The entire program was completed within 48 hours after initiation. The orientation program was completed when the brochure and handouts were distributed to the participants and

reviewed by the researcher, when the tour was completed and when all of the patient's questions were answered. The total time involved in the program was approximately two to two and one-half hours.

The second major concept in the study was interinstitutional relocation which is conceptually defined as "moving from one environment (the acute care setting) to another" (the extended care facility) (Rowles & Ohta, 1983, p. 189) or moving from one institution to another. In operationalizing this concept, interinstitutional relocation was defined as moving or transferring from the hospital setting to the extended care facility. For the purposes of this study only those individuals who were moving from a hospital to an extended care facility for the first time were included in the study. The participants arrived by ambulance or private car and may have been or may not have been ambulatory.

The third major concept included in this study was the concept of adaptation. Adaptation was defined conceptually as "anything that is changed or changes so as to become suitable to a new or special use or situation" (Morris, 1973, p. 14). In operationalizing the term adaptation for this study, the concept was expanded to identify a type of adaptation, in this case "more positive adaptation." It was hypothesized that the elderly individual who participates in the orientation program experienced "more positive adaptation" post-relocation than the study participant who was not exposed to the orientation program. Adaptation was to be measured utilizing:

1. A short questionnaire to measure knowledge of the facility's policies and procedures.

2. Social activity records to measure amount of patient socialization.
3. A statement regarding the staff's and the social worker's perception of socialization.

"More positive adaptation" was to be indicated by:

1. An increase in knowledge of the facility's policies and procedures pretest to posttest.
2. The amount of social activity at posttest.

It was hypothesized that the participants who were members of the experimental group would perform higher or at the same level as the control group members on the knowledge test pretest to posttest and would exhibit greater social activity than the control group members. The higher predicted performance of the experimental group was to be attributed to the effect of the orientation program.

Instruments

The instruments which were to be utilized in this study were identified as:

1. The Short Portable Mental Status Questionnaire.
2. A short questionnaire regarding knowledge of the extended care facilities and procedures.
3. A Social Activity Record.
4. The Socioeconomic and Demographic Questionnaire.

Pilot Testing of Instruments

The SPMSQ and the knowledge questionnaire were pilot-tested for readability with three to four elderly nursing home residents. The



questionnaires were piloted by both the researcher and the trained volunteer who were administering the instruments for the study. The residents were selected by the Director of Nursing for the pilot group and were alert, oriented and 55 years of age or older.

SPMSQ

The Short Portable Mental Status Questionnaire (SPMSQ) is a standard test of mental status which is used to assess memory, orientation and calculation (Winograd, 1984) (see Appendix B). It is a ten-item test of orientation, recent memory, long-term memory and capacity for serial calculation (p. 50). The SPMSQ is a short portable, reliable and valid standardized instrument and clinicians whose practice includes any significant number of elderly patients need such an instrument (Pfeiffer, 1975, p. 433).

The Short Portable Mental Status Questionnaire (SPMSQ) was to be utilized to measure the participants' mental status 48 hours post-relocation and again at one month post-relocation. The SPMSQ was to be utilized: 1) to indicate initial differences which were present between the experimental and control groups; and 2) to provide a description of the characteristics of the sample. The SPMSQ was to be utilized at posttest in one month to note any changes in the participants performance from admission to one month post-relocation.

The SPMSQ was administered by a trained volunteer and the scoring was accomplished by the researcher. According to Winograd (1980), the SPMSQ is scored on the number of correct responses adjusted for years of education and race:



0 to 2 errors are presumed to correlate with intact intellectual function.

3 to 4 errors with mild intellectual impairment.

5 to 7 errors with moderate intellectual impairment.

8 to 10 errors with severe intellectual impairment.

"The total sum of the errors, adjusted for educational level, provides a benchmark for determining the level of intellectual functioning of the client" (Cairl, Burton, Keller, Kosberg, Pfeiffer, 1985, p. 10).

Knowledge Questionnaire

The knowledge questionnaire regarding the participant's knowledge of the policies and procedures of the extended care facility is a ten-item questionnaire which was to test the knowledge level of the participant at pre and posttest. The questionnaire was to be administered at admission and at one month post-admission. The questionnaire was designed to test the participants' knowledge regarding the content in the orientation program, i.e., meal time, services offered by the facility, and layout of the facility (see Appendix C). The questionnaire was given after the SPMSQ and was administered utilizing an interview format.

Social Activity Record

The Social Activity Record is a tool which was established by the individual facility as a document on which the residents' social activities can be recorded on an individual basis (see Appendix D). The Social Activity Record was completed by the Activity Director and the day-to-day social activities were recorded for each resident.

Participation in formal social activities was not a requirement for inclusion in this study. For example, the participants may have socialized by attending meals in the dining room or by visiting a friend. The researcher was to review the Social Activity Records for each study participant at posttest one month post-admission. The researcher met with the Activity Director prior to the study to discuss the method for recording the social activities of the participants.

The social activity was to be scored by tallying the number of times the patient participated in formal social activities in a one month period. The number of times the participants in the experimental group participated in social activities was to be compared to the number of times the control group participated in social activities in a one month period post-relocation. The results were to be compared and differences reported.

Social activity was also to be evaluated by logging the social worker's and the charge nurse's assessment of the patient's social activity. The social worker's notes were to be checked and the patient's social activity was to be noted. The charge nurse's perception of the amount of social activity experienced by the participants was also to be recorded.

Socioeconomic and Demographic Questionnaire

The Socioeconomic and Demographic Questionnaire is an 18-item questionnaire. The first 14 items were obtained from the study participants. The researcher administered the Socioeconomic and Demographic Questionnaire utilizing an interview format after



explaining the study on a one-to-one basis and after obtaining consent from the participant. The responses to items 15 to 18 on the questionnaire were obtained from the client's record from the social worker or from the admission secretary.

Data Collection Procedures

The researcher was notified by the agency regarding all newly admitted patients, and the researcher explained the study on a one-to-one basis, obtained consent and administered the sociodemographic questionnaire with the participant. The researcher assigned the participants an identification number. Every other admission went to the control group. Even numbers were assigned to the experimental group and odd numbers to the control group. The researcher notified the trained volunteer to administer the pretest instruments: The Short Portable Mental Status Questionnaire (SPMSQ) and the knowledge questionnaire.

The SPMSQ and the knowledge questionnaire were administered by a trained volunteer. The social activity data retrieval was to be accomplished by the researcher. The volunteer administered the SPMSQ and the knowledge questionnaire. The volunteer administered both measurement tools within "24" hours of admission in either the patient's room or another private, quiet, well-lighted area. The administration of the instruments was accomplished in an informal, relaxed manner utilizing an interview format. The volunteer administered the SPMSQ to the patient and the volunteer wrote in the responses. The volunteer administered the knowledge questionnaire



which tests the participants' knowledge of items regarding patients' rights, visiting hours, services, social activities, meals and medications. The volunteer read the items to the participant and recorded the participant's responses.

The volunteer was to administer the measurement tools at both pretest and posttest and the researcher was to code and record the data. The researcher was to gather and code the data regarding the participants' social activity and/or level of socialization. The formal social activity was recorded on a daily basis by the Social Activity Director from admission and the data was to be collected at one month post-admission by the researcher.

In order to provide an accurate measurement of the concept of adaptation, the participants were requested to hold any questions which did not relate specifically to the testing procedure until after administration of the instrument. Reassurance about or guidance of the participant regarding their relocation experience could have biased the study results.

Confidentiality was assured for each study participant and the researcher addressed the issue of confidentiality with each subject individually. The issue of confidentiality was also addressed in the Patient Bill of Rights and each participant in both groups received the Patient Bill of Rights brochure upon admission.

Each participant was expected to complete the sociodemographic questionnaire and the pretests within 24 hours of admission and the posttests one month after admission. If any of the participants were unable to complete the program for any reason the researcher or the



volunteer would have stopped the program at that point. If the participant was able to resume his/her participation in the program, the researcher would have determined if the participant was within the time restrictions which had been set for administering the questionnaires and if so continued the program with the participant. If the participant was unable to continue within the time frame for the questionnaire administration or was unable to continue for any reason, the participant was to be removed from the study.

Each participant was required to remain in the study for one month after enrollment in the study. At the end of one month, the posttests were to be administered. If the participants did not remain in the study for one month or were not capable of participating in the administration of the questionnaires at one month post-relocation, those participants were to be automatically removed from the study.

Chart Audit

In order to determine the occurrence or presence of extraneous variables which may have affected the participant's adaptation to the extended care facility or participation in the study, a chart review was completed. The chart review was conducted by the trained volunteer and the researcher, utilizing: 1) a list of common events or condition changes which may have influenced the resident's adaptation to relocation from the hospital to the extended care facility; and 2) a list of items related to the overall physical condition of the participant (see Appendix E). The items were marked as conditions which had occurred or changed or conditions which had



not occurred or changed from admission to one-month post-relocation by marking the items "yes" or "no." The data was to be retrieved on each participant and the results of the audit were to be reported in conjunction with the data analysis.

Reliability and Validity of Study Measures

SPMSQ

Reliability

Reliability of a measurement instrument is defined as "the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure" (Polit & Hungler, 1983, p. 621). The SPMSQ is described in the literature as a reliable instrument for assessment of an elderly client's level of intellectual functioning (Cairl et al., 1985; Gurland, 1980; Pfeiffer, 1975; Winograd, 1980).

According to Pfeiffer (1985) "a four-week test-retest of the SPMSQ produced a reliability coefficient of .82 and .83 for two groups of aged subjects" (p. 712). The SPMSQ is also viewed as a reliable instrument in differentiating organic and functional disorders according to Wolber, Romaniuk and Eastman (1984).

Gurland (1980) reports that the SPMSQ is a reliable and valid tool in a report of mental health status assessment of older adults. Gurland (1980) reports that the SPMSQ is a reliable tool for assessing both degree of mental impairment and ability to carry out activities of daily living (ADL).

Pfeiffer (1975) described the SPMSQ as a short, reliable instrument which detects the presence of intellectual or cognitive

impairment. Reliability for the SPMSQ was established utilizing two groups aged 65 and older ($N = 30$ and $N = 29$) who were given the SPMSQ twice at four week intervals to determine stability of response. The test-retest correlations were reported as .82 and .83, respectively.

"The findings from these studies indicate that the responses to individual questions and the total error score on the SPMSQ are remarkably stable, indicating no significant practice effect or deterioration in performance over this length of time" (Pfeiffer, 1975, p. 439).

Validity

Validity of a measurement instrument is defined as "the degree to which an instrument measures what it is intended to measure" (Polit & Hunger, 1983, p. 624). The validity of the SPMSQ has been established by several researchers (Gurland, 1980; Pfeiffer, 1975; Wolber et al., 1984). The SPMSQ is considered to be valid in differentiating organic and functional disorders as well as level of intellectual functioning.

The validity of the SPMSQ was established by Pfeiffer (1975) when it was administered to "two non-random populations of the elderly: 1) 141 subjects aged 50 or over referred for evaluation to the OARS clinic at the Duke University Center OARS clinic for the Study of Aging and Human Development; and 2) 102 subjects aged 65 or over from the same county as a community survey population, who were already living in institutions (p. 438).

In the two non-random populations of elderly, face validity was established for the SPMSQ in relation to organic impairment. There



was 92% agreement between diagnoses of organic brain syndrome (OBS) and the SPMSQ score for 133 out of 141 subjects in the OARS clinic at Duke University when definite impairment was indicated. Also, there was 82% agreement when the SPMSQ indicated mild or no impairment related to OBS.

Knowledge Questionnaire

Reliability

Reliability was established in this study for the SPMSQ by further assessment of the tool for stability, however reliability for the knowledge questionnaire has not been established at this time. The readability of the knowledge questionnaire was assessed from a pilot test of the instruments on a small population of elderly individuals who are currently institutionalized (three to four subjects).

Validity

The content validity of the knowledge questionnaire regarding the extended care facility's policies and procedures was established. The content validity of the measure was established by the thesis committee. Criterion-related and construct validity will not be established for the knowledge questionnaire during the course of this study.

Social Activity Record

Reliability

The accuracy of the reporting of the participants' social activity depended on the accuracy of the recording by the Social

Activity Director. Therefore, the reliability of the report depends upon the reliability of the rater(s) whose reliability is unknown.

Validity

The content validity of the Social Activity Record was established by the thesis committee. Criterion-related and construct validity was not established for the Social Activity Record during the course of this study.

Scaling

After testing the participants' mental status and knowledge at pretest and posttest and the social activity at posttest, the measures were to be scored. The SPMSQ was scored by summation of the errors and was adjusted for educational level (see Table 1).

The knowledge questionnaire was to be scored at pretest and posttest by summation of incorrect responses and reporting of the number of incorrect responses out of a possible score of 15. The Social Activity Record was to be scored at one month post-admission by summation of the number of social activities in which each participant was involved.

Data Analysis

The technique of analysis which was to be utilized in this study was a t-test. A t-test was to be utilized to analyze the differences between the experimental and control groups after the orientation program. The difference in knowledge between the experimental and control groups pretest to posttest was to be compared. A t-test was also to be computed for the difference in scores of the treatment and



Table 1: Short Portable Mental Status Questionnaire Summation

Adjusted Score	Clinical Significance
0-2 errors	Intellectually intact.
3-4 errors	Mild cognitive impairment. Client is somewhat forgetful and may need to depend on memory aids such as calendars, memos, or lists to facilitate functioning.
5-7 errors	Moderate cognitive impairment. Client may have problems functioning totally independently, forgetting to take medications, to turn off stove after cooking, or to pay monthly bills.
8-10 errors	Severe cognitive impairment. Client is unable to function without assistance and is likely to need almost constant supervision.

control groups regarding the amount of social activity the participants experienced. The level of statistical significance which was to be considered acceptable was .05 for both knowledge and social activity.

Reporting t-tests results would have indicated the statistical significance of the questionnaire results. After analyzing the significance of the knowledge questionnaire and social activity results, the effectiveness of the orientation program could have been determined.



An alpha coefficient was to be utilized to determine the correlation between items on the knowledge questionnaire, or to determine the internal consistency of the knowledge measure. The alpha coefficient was to be determined after the pre and posttest measures were completed for the knowledge questionnaire.

Simple means were reported for the categories which were extrapolated from the chart audit report. The mean measures were determined to be a method by which the types of categories (i.e., number of certain diagnoses, physical disabilities, condition changes) could be reported.

Protection of Human Subjects

After the data analysis had been completed, the results were reported. Protection of the anonymity of the participants was mandatory. Protection of the participants' rights throughout the entirety of the study was also a necessity. Specific guidelines regarding participants' rights should be adhered to in order to assure anonymity and confidentiality.

In this study, the rights of the participants were protected by:

1. Obtaining informed consent from each participant which was witnessed by another party. If the participant had a legal guardian, the guardian signed for the participant.
2. Assuring freedom from harm, privacy, anonymity and confidentiality.
3. Submitting the research proposal for approval to the University Committee on Research Involving Human Subjects.



4. Assuring that the control group received the usual treatment upon relocation; nothing was to be deleted from their treatment.

The records which were kept on each participant were confidential and the researcher had access to them. The trained volunteer had access to the medical records of the participants in assisting with the chart audit.

Summary

The methodology which was utilized and the procedures which were instituted in order to accomplish a study involving the effects of relocation on the elderly individual who is transferring from the acute care setting to an extended care facility have been defined. The data collection procedures and the data analysis techniques have been prepared and after collection and analysis of the data was completed, the data was presented and analyzed.



CHAPTER V

Data Presentation and Analysis of Results

Overview

The purpose of this chapter is to present the analysis of the data and a discussion of the interpretation of the results. Additionally, the researcher will report the difficulties which were encountered during data collection, the resultant procedural changes which occurred, and questions which arose related to the collection of data. The content of this chapter includes (1) the study findings and (2) a discussion of the reported findings relative to study hypotheses.

Study Findings

The focus of the study was on the feasibility and effectiveness of an orientation program by a registered nurse within 48 hours of admission for newly admitted elderly patients at a nursing home in the Midwest. The study was an experimental study of 66 subjects who were admitted from an acute care setting to a 167 bed skilled nursing facility. The study was conducted over a four month period from January 1, 1987 to May 1, 1987.

Sample Characteristics

Eligibility Criteria

Out of 66 admissions over the designated four month period of study, eight subjects were eligible for enrollment in the study according to the study criteria. The study criteria were:

1. The subjects were transferred from the acute care setting to the extended care facility.
2. The subjects had experienced no previous admissions to an extended care facility.
3. The subjects had planned to stay at the facility for at least one month.
4. The subjects, if diagnosed as having dementia, Alzheimer's disease or organic brain syndrome were able to respond to the screening items on the Sociodemographic Questionnaire.
5. The subjects were able to speak, understand, read and write English.
6. The subjects were capable of answering questions coherently.
7. The subjects were 55 years of age or older.
8. The subjects voluntarily agreed to participate and cooperate in the study and were willing to participate upon request in a brief orientation program to introduce him/her to the facility.
9. The subjects were able to communicate their responses to the researcher if they were aphasic, blind or hearing impaired.
10. The subjects were mobile so that they were able to complete the tour of the facility (ambulatory/wheelchair bound).
11. The subjects identified a family member/significant other who was responsible for their care.

The subjects in the study were assigned to the study from the population of individuals who were being transferred from the acute care setting to the extended care facility for the first time. The



subjects were screened from the sample utilizing the Sociodemographic Questionnaire (see Appendix A).

Number of Participants

Of the 66 individuals who were admitted to the skilled nursing facility over the period of four months in which the study was being conducted, eight subjects were eligible for enrollment in the study according to the study criteria. Of the eight subjects who were eligible for enrollment in the study, three remained eligible to participate in the study at the time of the posttest which was one month post-admission. Of the three participants who remained in the study, two subjects were members of the control group in which no orientation program was completed, and one subject was a member of the treatment group.

The remaining five subjects were unable to complete the requirements of the study for the following reasons:

1. One participant was discharged home before the posttest was completed.
2. One participant's mental status deteriorated to a point at which the participant was too confused to respond to the posttest questionnaire.
3. Two participants were discharged to the hospital before completion of the posttest.
4. One participant died prior to the posttest.

Pretest Findings

Pretest information was gathered on eight subjects. The ages of the subjects ranged from 74 to 90. The mean age of the pretest group was 85.

The physical status of the eight subjects who participated in the pretest was variable. Seven of the eight subjects were females.

Their physical disabilities were listed as:

1. Parkinsonism
2. Post-coronary bypass
3. Dementia
4. CHF with permanent pacemaker
5. Cerebral ischemia
6. Fractured left hip
7. Pneumonia
8. Metastatic carcinoma

None of the participants for the pretest were ambulatory on admission and all required assistance in activities of daily living. The reasons for admission for each member of the pretest group varied according to their medical diagnosis, but all of the individuals had been admitted to the skilled nursing facility because they were not able to be in their own home at the time of their admission for one reason or another.

SPMSQ

The Short Portable Mental Status Questionnaire (SPMSQ) was administered to each of the eight pretest participants. Four of those participants scored 0-2 errors, (intact intellectual function),



three scored three to four errors (mild intellectual impairment), one subject scored 5-7 errors (moderate intellectual impairment), and no subjects scored 8-10 errors (severe intellectual impairment).

Table 2: Short Portable Mental Status Questionnaire Scoring

<u>SPMSQ</u>	<u>Number of Subjects</u>	<u>Percent of Subjects</u>
0-2 errors	4	50%
3-4 errors	3	38%
5-7 errors	1	13%
8-10 errors	0	

Knowledge Questionnaire

The Knowledge Questionnaire was also administered to the pretest group. The knowledge questionnaire was designed to test the participants' knowledge regarding the content of the orientation program, i.e. mealtimes, services offered by the facility (see Appendix C). The questionnaire was a ten-item questionnaire.

None of the pretest group answered all of the questions correctly on the pretest. When reviewing the pretest item by item, the following results were obtained from the ten questions in the Knowledge Questionnaire (see Appendix C).

According to the results of the pretest knowledge questionnaire (see Table 3), the questions which were answered correctly most frequently were related to obtaining the services of a dentist, podiatrist, barber and/or beautician. The item on the pretest

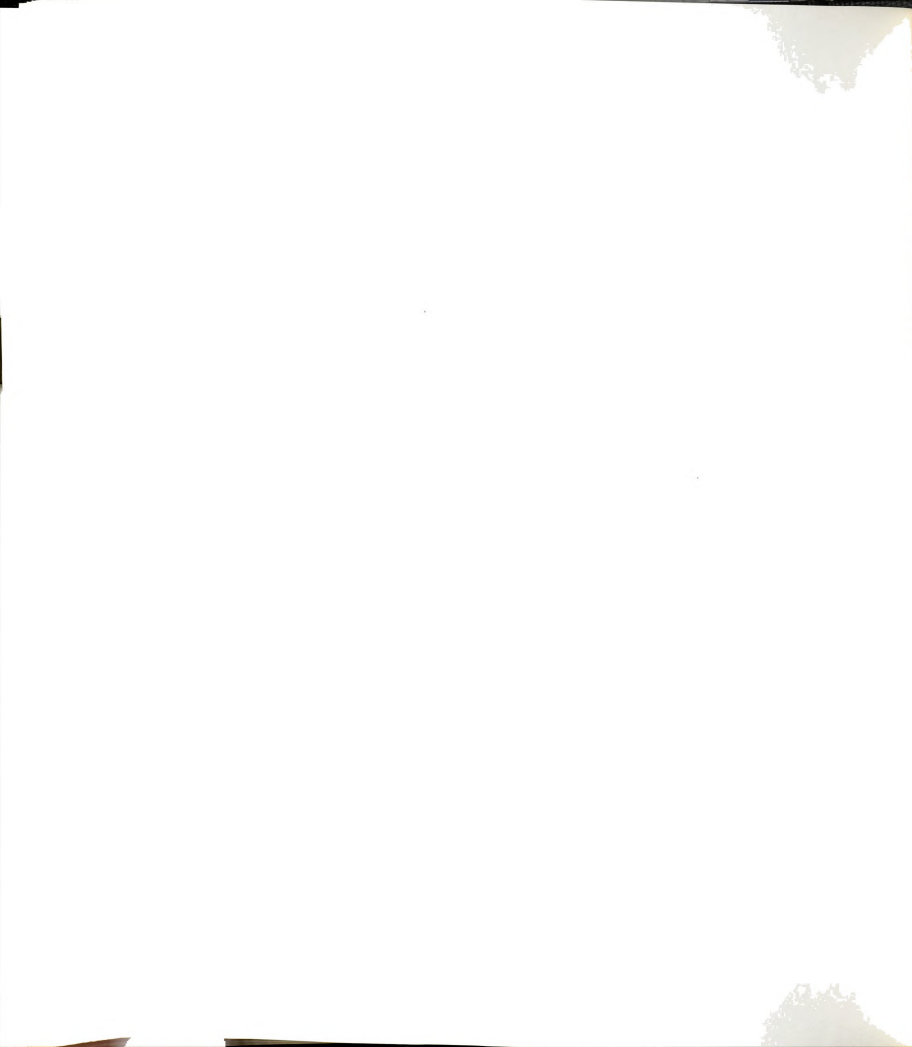
knowledge questionnaire which was most frequently incorrect was the item related to the patient's Bill of Rights. All of the pretest group members missed the item related to the Bill of Rights for residents of nursing homes scoring zero on that item.

Table 3: Knowledge Questionnaire Scoring

<u>Item</u>	<u>Number Correct</u>	<u>Percent of Subjects</u>
1. Two Rights (Bill of Rights)	0	0
2. Visiting Hours	2	25%
3. Departments which provide service	3	38%
4. Dental/Podiatry Services	5	63%
5. Beautician/Barber Services	5	63%
6. Location of Beauty Shop	2	25%
7. Activities available	4	50%
8. Location of activities	2	25%
9. Mealtimes	3	38%
10. Medication times	<u>1</u>	13%
TOTAL	27	

Posttest Findings

There were no posttest results to report in this study. Therefore, tests of significance were not performed relative to the hypotheses of this study. Tests of significance were not accomplished due to limitations in this study which were identified



as insufficient numbers of study participants, lack of access to additional skilled nursing facilities in the area, and lack of uniformity among skilled nursing facilities which would have confounded the study results.

The acuity level of the patients who were being admitted from the acute care setting was high. Acuity level is defined as the amount of or level of nursing care which is required to be carried out for an individual patient.

The patients who were being admitted to the skilled nursing facility as potential candidates for the study repeatedly failed to meet the study criteria for various reasons, i.e., mental confusion, physical deterioration, inability to communicate. As a result of the small number of study participants, the experimental intervention was stopped at the end of four months.

The researcher was not able to fulfill the requirements of the design of the study due to lack of subjects, and therefore, (1) the socialization records were not reviewed, (2) the charge nurses' and social worker's impressions related to social activity were not recorded, (3) the amount of social activity at posttest could not be measured on a Likert type scale as intended and (4) the experimental and control group's ratings on the knowledge questionnaire and SPMSQ could not be compared at pre and posttest for any differences.

Therefore, the findings of the experimental study lead the researcher to an additional research question relative to the characteristics of the nursing home population. The additional

question became: What are the characteristics of the skilled nursing facility population at the time of admission to the setting?

Additional Findings

In an effort to answer the additional research question regarding the characteristics of the nursing home population, the following analyses were conducted.

Methods

A medical record audit on an independent sample of 22 subjects who were admitted to the skilled nursing facility from January 1, 1987 to May 1, 1987 was accomplished. The researcher sent a letter to each of the 66 persons who were admitted to the skilled nursing facility from January 1, 1987 to May 1, 1987. Permission was requested from each individual or from that individual's responsible party in the event that they could not give permission themselves to audit the patient's medical record and 22 persons responded that they would be willing to participate in the medical record audit.

The researcher obtained written consent from the patient or responsible party to complete the medical record audit. The audits were completed by a trained volunteer who was in a non-nursing profession and by the researcher within two weeks of obtaining consent. The findings of the medical records audits are representative of a population of elderly individuals who were being transferred from the acute care setting (hospital) to the skilled nursing facility.



Two chart review forms were utilized for the audit of each subject's medical record in addition to use of the sociodemographic questionnaire for data retrieval. The purpose of the chart review forms was to provide a standardized format for retrieval of data which was related to the physical status of each of the subjects, to any assistive devices which were utilized by the subjects throughout their stay at the facility, speech and communication abilities of the subjects, and occurrence of death, and/or discharge post-relocation. The medical record audit also was utilized to retrieve data related to social and physical changes or events which occurred during the subjects' stay at the skilled nursing facility. The data was retrieved during the period from admission to the facility to 30 days post-admission. The 30 day period for data retrieval was the same as the length of time between pretest and posttest for the original designed planned experimental study.

Independent Sample

The audit sample is comprised of 22 individuals who ranged in age from 57 to 94. The mean age of the group was 80. Nineteen individuals in the sample were females and three individuals were males. The mean age of the male population was 83, and the mean age of the female population was 79 (see Table 4).

According to the audit of the records utilizing the sociodemographic questionnaire, within the female group there were 11 who were widowed, six who were married and one who was single. There was one widowed male and two married males in the population. All subjects were Caucasian and all but one individual spoke English as

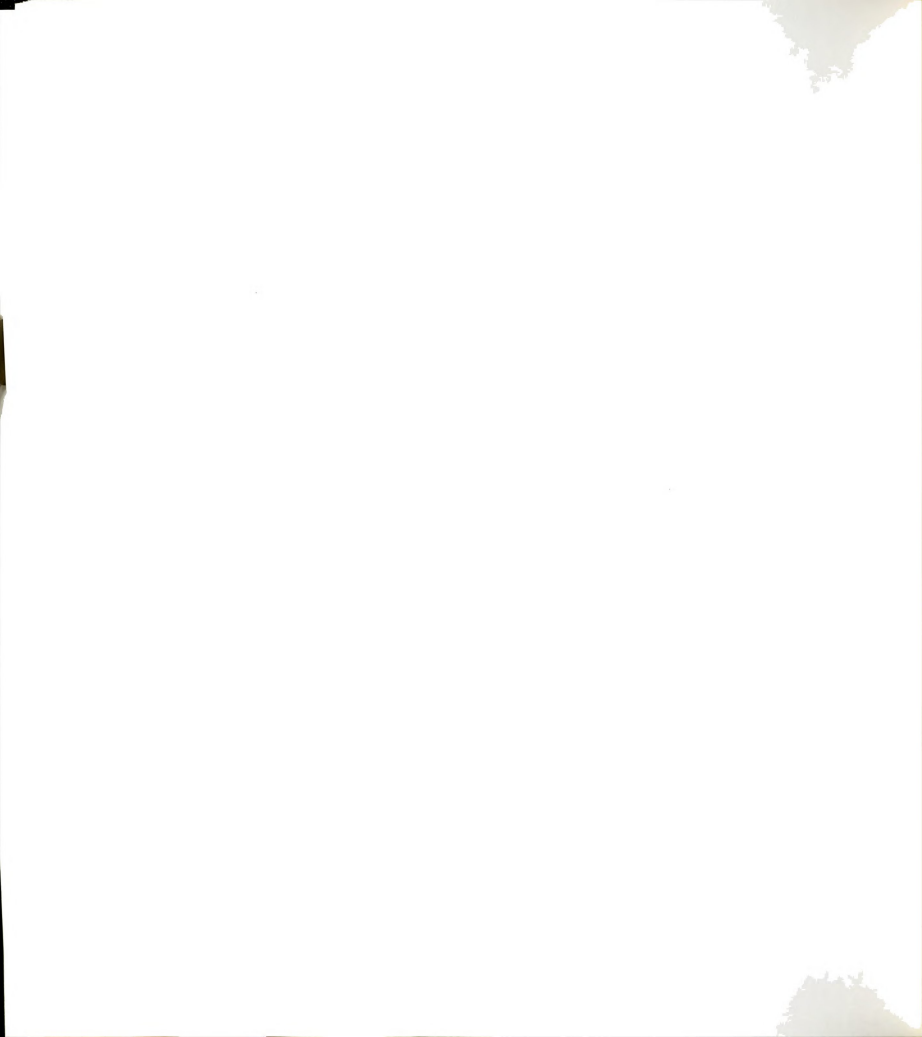


Table 4: Summary of Sociodemographics of Chart Audits

	<u>FEMALE</u>	<u>MALE</u>	<u>TOTAL</u>
Age	Range: 57-94 Mean Age: 79.6	Range: 75-91 Mean Age: 83	Range: 57-94 Mean Age: 80
Race	All Caucasian	All Caucasian	22
Marital Status			
Married	6	2	8
Widowed	11	1	3
Single	1	0	1
Divorced	1	0	1
Education			
< High School	*	*	
High School	*	*	
> High School	1	0	1
Familiarity with Nursing Homes			
Resident Before	10	2	12
Family Member In	1	--	1
Told About	1	--	1
Toured	1	--	1
Medical Insurance			
Medicare	17	3	20
Medicaid	1	0	1
Blue Cross	15	3	18
Health Plus	3	0	3
Responsible Party			
Friends	2	--	2
Family	16	3	19
Trust Officer	1	--	1
Length of Stay			
Indefinite	15	2	17
Short Term	4	1	5

*not documented in record



the primary language spoken. There was no indication on one individual's medical record as to language(s) spoken (see Table 4).

The individuals' medical records were audited for educational level (highest grade completed) and religious preference. Information relating to educational level was available on only one subject's medical record and the individual whose educational level was indicated was a college graduate (see Table 3). According to the sociodemographic screening, there were 15 individuals who were Protestant and seven who were Catholic in the sample.

Hospitalizations

The number of prior hospitalizations in the past five years (1981- 1986) was noted for each subject. Fourteen subjects had experienced one to five prior hospitalizations in the past five years, "multiple" or "numerous" hospitalizations were recorded for three of the study participants and the number of prior hospitalizations was not noted for five of the subjects. The number of prior nursing home admissions was also noted on each subject. Four of the subjects had no prior nursing home admissions, ten of the subjects had one prior nursing home admission and eight of the subjects' records had no notation regarding prior nursing home admissions.

Familiarity with Nursing Home Procedures

Familiarity with nursing home procedures was noted for each subject in the study. Ten subjects were familiar with nursing home procedures (had been a resident in a nursing home before). One subject was familiar with nursing home procedures (had a family

member in a nursing home). One subject was familiar (had been told about this nursing home) and one subject was familiar (had toured this nursing home). Familiarity with nursing home procedures was not recorded on nine of the medical records which were audited (see Table 4).

Medical Insurance

The type(s) of medical insurance(s) which the study participants carried was summarized. All 22 subjects carried some form of medical insurance. Twenty of the subjects carried Medicare, three subjects carried Health Plus (HMO), one subject carried Medicaid and several subjects carried another commercial insurance in addition to Medicare (see Table 4).

Responsible Party

All study participants identified a responsible party and 19 of the responsible persons were family members. Two of the responsible parties were identified as friends of two of the subjects and one was identified as a trust officer. Legal guardianship was not identified in the medical record, so it is not known how many of the responsible parties were also legal guardians or had durable power of attorney (see Table 4).

Admission Diagnoses

The current admitting diagnoses which were observed for the study participants are listed in Table 5. The most frequently noted admitting diagnosis was cerebrovascular accident or post-cerebrovascular accident and there were 23 diagnoses that were noted once only.



Table 5: Admitting Diagnoses

-
1. CVA/Post CVA (7)
 2. Dehydration (4)
 3. Organic Brain Syndrome (3)
 4. Hypertension (2)
 5. Congestive Heart Failure (2)
 6. Diabetes Mellitus (2)
 7. Parkinson's Disease (2)
 8. Pneumonia (2)
 9. Severe Hypoglycemia
 10. Above the Knee (L) Leg Amputation
 11. Atrial Fibrillation
 12. Mitral Valve Replacement
 13. Cancer of Colon
 14. Transient Ischemic Attack
 15. Arteriosclerotic Heart Disease
 16. Multiple Fractures
 17. Post-Subdural Hematoma
 18. Urinary Tract Infection
 19. Gastrointestinal Bleeding
 20. Contusion Lumbar Spine
 21. Osteoporosis
 22. Cerebral Ischemia with Left Hemiplegia
 23. Arthritis
 24. Hip Replacement (left)
 25. Fractured Hip
 26. Post-Colostomy; Flaccid Bowel
 27. Dementia
 28. Cancer of Prostate
 29. Sacrococcygeal Decubitus Ulcer
 30. Anemia
 31. Pulmonary Edema
-



Physical Status

The physical status of the individuals was obtained utilizing a standardized review form. Each subject's vision, hearing, chronic illness and other physical problems/illnesses, physical disabilities, assistive devices, speech/communication, death, discharges, social and physical changes or events was noted.

The subjects' vision was recorded as: poor (4); blind left eye (2); adequate with glasses (2); adequate (2); blind right eye (1); comatose (1); not recorded (10). The subjects' hearing was reported as adequate (8); poor (3); fair (1); excellent (1) and not recorded (9).

The most frequently reported chronic illness was CVA (cerebrovascular accident/stroke)(10); followed by hypertension (7); arthritis (5); kidney/urinary tract disease (5); glaucoma/cataracts (3); diabetes mellitus (3); cancer/leukemia (2); Parkinson's disease (2); and fractured hip (1). Other physical problems/illnesses were listed as congestive heart failure (4); dehydration (4); arteriosclerotic heart disease (3); organic brain syndrome (3); fecal impaction (2); atrial fibrillation (2); decubitus ulcer coccyx (2); osteoporosis (2); urinary tract infection (2). Several other physical problems/illnesses were listed once.

The chronic illnesses which were identified in the medical record audit are cited in Table 6.

The most frequently cited chronic illness was stroke and the least frequently cited chronic illnesses were emphysema/chronic bronchitis, nervous disorders and Alzheimer's Disease in this

Table 6: Summarization of Chronic Illness Scoring

	Female	Male	Total
Chronic Illness(es)	N = 19	N = 3	Number
Arthritis	5	0	5
Glaucoma/Cataracts	3	0	3
Emphysema/Chronic Bronchitis	0	0	0
Hypertension	7	0	7
Diabetes Mellitus	2	1	3
Kidney/Urinary Tract Disease	4	1	5
Cancer/Leukemia	1	1	2
Stroke (CVA/TIA)	10	0	10
Parkinson's Disease	1	1	2
Nervous Disorders	0	0	0
Broken (fractured) Hip	1	0	1
Alzheimer's Disease	0	0	0
Other	--	--	52

population. All of the male subjects were noted to have two or more chronic illnesses, and 16 out of 19 of the female subjects were noted to have two or more chronic illnesses. The highest number of chronic illnesses was noted to be ten chronic illnesses for one female subject.



Disabilities

The physical disabilities which were reported were total paralysis (0); partial paralysis (4); missing/nonfunctional limbs (2); broken bones (2). Assistive devices which were recorded as utilized by the subjects were: wheelchair (18); cane/walker (11); catheter (11); feeding tube (8); intravenous (3); tracheostomy (1); leg brace (1); and other: restraints (physical) (3); oxygen (1); water mattress (1); air mattress (1); suction machine (1); and dressings (1) (see Table 7).

Speech and communication patterns of the subjects were recorded as: speaks normally (15); unable to speak, but communicates (5); and unable to communicate (2) (see Table 7).

Course of Institutionalization

There were no reports of any deaths post-relocation from admission to one month post-admission, however, several discharges from the skilled nursing facility were noted. The length of stay at the skilled nursing facility ranged from six days to indefinite in the study population. Four of the subjects returned to their homes upon discharge; six subjects were discharged to the hospital including one male subject who was discharged to the hospital 11 days post-admission, was readmitted within five days, and was discharged again after a ten day stay at the skilled nursing facility; and one subject was discharged to Adult Foster Care. Seven of the subjects who were discharged left within 30 days of admission (see Table 7).

Seven of the subjects had discharge plans in place and 15 subjects had no record of discharge plans. Eleven subjects (50%) moved from one room to another but none of the subjects were found to have a room rate change.



Table 7: Summarization of Physical, Communication and Discharge Status (Form 1)

	Male	Female	Total
Physical Disabilities			
Total paralysis	--	--	0
Partial paralysis	--	4	4
Missing limbs	--	2	2
Broken bones	--	2	2
Assistive Devices			
Cane/Walker	2	9	11
Wheelchair	2	16	18
Leg brace	--	1	1
Back brace	--	--	0
Artificial limb	--	--	0
Catheter	2	9	11
Respirator/Ventilator	--	--	0
Trach --	1	1	
Feeding tube	1	7	8
IV --	3	3	
Other: oxygen	1	--	1
air/water mattress	--	2	2
restraints	1	2	2
suction	--	1	1
dressings	--	1	1
Speech/Communication			
Normal	2	13	15
Unable to speak	--	5	5
Unable to communicate	1	1	2
Deaths -- post-relocation	--	--	0
Discharge*			
To hospital	2	4	6
To home	--	4	4
Other: Adult Foster Care	--	1	1

*indicates that not all discharges were completed in one month



There were no recordings on any of the subjects related to death of a loved one or private duty nurses present.

Fourteen subjects attended physical therapy, eight subjects attended occupational therapy and four subjects attended speech therapy of the 22 subjects whose records were audited. Attendance in therapy was recorded if the subjects attended the therapies at any time during the 30 days from admission to 30 days post-admission (see Table 8).

The physical changes or events which were audited utilizing the second audit form were occurrence of: 1) infection(s); 2) pain; 3) bleeding; 4) medication reactions; 5) falls; 6) post-operative complications; 7) complications of bed rest; 8) change in level of responsiveness; and 9) alteration in nutrition (see Table 8).

The physical changes or events were audited and the number of subjects experiencing infections during the first 30 days post-admission was eight and the number of subjects experiencing pain which was reported and documented by the nurse was eight. There was one subject who experienced bleeding (hematuria); there were no recorded medication reactions and no recorded falls. The number of post-operative complications noted were two and there were 11 subjects (50%) who experienced complications of bed rest. Three subjects experienced change in level of responsiveness: 1) from responding completely to no response during the one-month period post-admission; 2) frequent change in responsiveness; and 3) becoming restless and confused at times.

Table 8: Summary of Medical Record Audit (Form 2)

	Male	Female	Total
<u>Social and Physical Changes or Events</u>			
Presence of Family Support			
Daily	--	10	10
More than one time weekly	2	3	5
Weekly	--	1	1
Support, but no visits	1	2	3
No support, no visits	--	3	3
Discharge Plans	--	7	7
Moved Room to Room	1	10	11
Room Rate Change	--	--	0
Death of a Loved One	--	--	0
Private Duty Nurse(s)	--	--	0
Therapy			
Physical therapy	3	11	14
Occupational therapy	2	6	8
Speech therapy	--	4	4
Social Worker Involvement	3	18	21
<u>Physical Changes or Events</u>			
Infections	1	7	8
Pain	1	7	8
Bleeding	1	0	1
Medication Reactions	--	--	0
Falls	--	--	0
Post-Operative Complications	--	2	2
Complications of Bed Rest	2	9	11
Change in Level of Responsiveness	1	2	3
Alteration in Nutrition	2	4	6

The final item which was audited relating to physical changes was nutritional alterations. Alterations in nutrition were recorded on six subjects with the alterations noted as jejunostomy, gastrostomy, nasogastric tube feeding, loose fitting dentures, dysphagia with decreased intake and poor appetite (see Table 8).

Social Activity/Social Events

The social changes or events which were audited on the second audit form were: 1) presence of family support; 2) presence of discharge plans; 3) movement from one room to another; 4) occurrence of room rate changes; 5) death of a loved one; 6) presence of private duty nurses; 7) attendance at therapies; and 8) social worker involvement on a regular basis (see Table 6).

Twenty-one of the 22 subjects were reported to have had social worker involvement on a regular basis. Involvement on a regular basis by the social worker was defined as visits from the social worker at admission and at least monthly thereafter.

Nineteen subjects were identified as experiencing presence of family support. Ten subjects received visits daily; four subjects received more than one visit weekly; one subject received visits weekly; one subject received visits three times weekly; three subjects were identified as having support, but the frequency of visits was not recorded; and three subjects were identified as having no support and no visits (see Table 8).

The findings of the medical record audit were summarized. The results of the audit were reviewed and conclusions regarding the reasons the newly admitted patients to the skilled nursing facility

did not meet with the criteria for inclusion in the experimental study regarding the effects of and feasibility of an orientation program by a registered nurse upon newly admitted patients to a nursing home were determined.

Discussion

After summarizing the findings from the medical record audit which was accomplished for 22 subjects who were admitted to the skilled nursing facility in the study during the period from January 1, 1987 to May 1, 1987, it has been determined that there were multiple reasons for the alteration of the study plan. Of the 22 medical records audited, there were clearly defined recorded responses relating to the subject's potential for study participation based on the stated criteria. The reasons for ineligibility for the study are as follows:

1. Twelve of the subjects (55%) had been a resident of a nursing home before. According to the study criteria, in order to be eligible for the study the individual must not have experienced any previous admission to an extended care facility (nursing home).
2. Seven of the subjects (32%) were discharged from the facility prior to one-month post-admission. The study criteria was written such that individuals who participated in the study planned to stay at the facility for at least one-month.
3. Three of the subjects (14%) were diagnosed as having organic brain syndrome and dementia and were unable to respond to the



screening items on the Sociodemographic Questionnaire.

According to the criteria for inclusion in the study, the participants who were diagnosed with dementia, Alzheimer's disease or organic brain syndrome and were unable to respond to the screening items on the Sociodemographic Questionnaire were ineligible for inclusion in the study.

4. Seven of the subjects (32%) were unable to communicate responses to the researcher; five of the subjects were unable to speak and two were unable to communicate at all. According to the inclusion criteria for the study, the participants must have been able to communicate responses to the researcher if he/she was aphasic, blind, or hearing impaired. There were no blind subjects noted in the audit, but three of the subjects were noted to hear poorly.
5. Four of the subjects (18%) were identified as having partial paralysis and two subjects were identified as having missing/non-functional limbs. Eighteen subjects were wheelchair bound, 11 subjects used a cane or walker for mobility, and one subject used a leg brace. Eight subjects had feeding tubes, one subject used oxygen, three subjects utilized physical restraints and one subject had dressings which were conditions which limited the range of their mobility status. According to the study criteria, the participants were to be mobile so that they were able to complete the tour of the facility (ambulatory or via wheelchair).

The total number of subjects out of the 22 subjects who participated in the medical record audit who were ineligible according to the inclusion criteria to participate in the experimental study was 20. Of the remaining two subjects, one was recovering from pneumonia upon admission to the skilled nursing facility and was either too weak or too confused to participate in the study as required during the first 48 hours of admission. The other subject was experiencing pain and limited activity due to her post-operative status post-admission, and, therefore, was not eligible to participate in the tour of the facility.

The entire 22 subjects whose medical records were audited to determine their status regarding inclusion in the experimental study were ineligible for one or more reasons according to the study criteria. Also, of the eight participants who were initially enrolled in the study, only three remained eligible for inclusion in the study at one-month post-admission. Therefore, the feasibility of a registered nurse providing an orientation program for the 30 subjects who were either enrolled in the experimental study or who participated in the audit was very poor. It was not feasible for a registered nurse to successfully provide an orientation program to those subjects who participated in the study during the period from January 1, 1987 to May 1, 1987. Additionally, the effectiveness of an orientation program provided to the 30 subjects who were either enrolled in or audited during this study could not be measured.

Neither the feasibility of an orientation program nor the effectiveness of an orientation program by a registered nurse to



elderly individuals relocating from the acute care setting to the extended care facility can be determined due to the limitations of this study to include the inadequacy of the medical records related to communication status, discharge status, physical status and general well-being which were noted during the medical record audit. Therefore, the effects of relocation on an elderly individual's ability to adapt to the new environment when moving from an acute care setting to an extended care facility in terms of the patient's well-being, both objectively and subjectively could not be determined during the course of this study.

Summary

Due to the lack of available participants in the experimental study in this research, the study could not be completed as designed. The hypotheses which were tested in this study were neither accepted nor rejected as the study was not completed. The hypotheses which could neither be supported/accepted nor rejected were:

1. An elderly individual from an acute care setting who is provided an orientation program by a registered nurse from that facility will experience more positive adaptation than an elderly individual from an acute care setting who is not provided an orientation program by a registered nurse from that facility.
2. An elderly individual from an acute care setting who is provided an orientation program to an extended care facility will demonstrate a higher level of knowledge regarding the facility's

policies and procedures than an elderly individual from an acute care setting who is not provided an orientation program.

3. An elderly individual from an acute care setting who is provided an orientation program to an extended care facility will demonstrate a higher level of social activity than an elderly person from an acute care setting who is not provided an orientation program.

As the researcher was able to complete the intervention of the orientation program with only one subject, the number of participants was not sufficient to report significant study findings. However, the medical record audit which was accomplished retrospectively with 22 subjects was an attempt to examine the reasons for subject ineligibility and inability of the researcher to carry out an orientation program. Several conditions which caused the subjects to be determined ineligible for the study were identified and the hypotheses were neither rejected nor accepted.

CHAPTER VI

Summary and Conclusions

Overview

The purposes of this chapter are to present: 1) a summary of the research findings; 2) recommendations based on the findings; and 3) conclusions which have been derived from the research. The content of this chapter includes three sections: summary of findings, recommendations and conclusions.

Summary of Findings

Description of Study

In an experimental study of elderly individuals who were being relocated from the acute care setting (hospital) to an extended care facility (nursing home), the effects and the feasibility of an orientation program upon the relocated individual's adaptation were determined. The study was conducted at a 167-bed skilled nursing facility in the Midwest. The facility's policy was to accept newly admitted individuals from four large community hospitals in the area. The subjects for this research study who were enrolled in the program were admitted from one of the four community hospitals.

Purposes

The study was designed to determine the effect(s) and/or feasibility of an orientation program by a registered nurse upon the adaptation of the newly admitted elderly individuals. The idea for the study was derived from the researcher's long-term interest in the

differences between those elderly individuals who were admitted to the extended care facility for the first time who adapted very poorly and those elderly individuals who adapted very well to the new setting.

The specific purposes of the study were:

1. To investigate the effects of relocation on an elderly individual's ability to adapt to the new environment when moving from an acute care setting to an extended care facility in terms of the patient's general well-being, both objectively and subjectively.
2. To investigate the feasibility of the introduction of an orientation program by a registered nurse to elderly individuals relocating from the acute care setting to the extended care facility.
3. To determine the effectiveness of an orientation program by a registered nurse for the elderly individuals who were experiencing relocation from an acute care setting to an extended care facility.

Conceptual Framework

The purposes and hypotheses of the study were related to the effectiveness and feasibility of an orientation program for an elderly individual who was relocating from the acute care setting to the extended care facility, and to the concept of adaptation post-relocation. Therefore, the conceptual framework which was utilized in this study was based upon the Roy Adaptation Model of Nursing and the nursing process. The concepts within the framework

which have been defined are relocation, orientation, orientation program and adaptation.

In brief, the Roy Adaptation Model of Nursing is a model which "identifies the recipient of nursing care as an adaptive system" (Roy & Roberts, 1981, p. 43). In applying the Roy Adaptation Model of Nursing to the issue of relocation of the elderly individual, the relocation event is viewed as the stimuli/input. The elderly individual copes with the event, the individual's coping is effected by feelings, reactions, physical effects and mental status and output(s) are achieved. The output is either adaptation to the event or failure to adapt to the event. The response(s) are fed back through the system in the form of input and the system recycles (see Figure 1).

The Roy Adaptation Model of Nursing was the framework for the client's reaction to the relocation event and the nursing process became the vehicle by which the professional nurse could intervene in the relocation event. In providing an orientation program, the professional nurse was able to manipulate the stimuli and affect the type of input the individual received. As the individual takes in the orientation program as part of the input, he/she copes, effects his/her coping in the four adaptive modes and either adapts or fails to adapt (output). The professional nurse can make an assessment at the point at which the output information is fed back through the feedback process and provide another intervention as needed. Therefore, the nursing process is applied by the professional nurse to the Roy Adaptation Model of Nursing.

Problem Statement

The experimental intervention was designed to answer the question regarding the effect(s) of an orientation program upon the elderly individual's adaptation to the extended care facility. The elderly individuals were admitted from the acute care facility.

Variables

The variables in the study were identified. Orientation program was the independent variable and more positive adaptation was the dependent variable. "Orientation program" was defined as a plan of procedure to assist a person in an adjustment or adaptation to a new environment or situation. More positive adaptation was defined as a certain, accepted or affirmed change which is accomplished so as to become suitable to a new situation.

Therefore, the positive adaptation was to be measured as:

1. An increased knowledge level as evidenced by the elderly client's improved performance on the knowledge questionnaire pretest to posttest.
2. An increase in socialization as evidenced by the elderly client's increase in social activity at posttest.

Hypotheses

The hypotheses which were formulated for this study were:

1. An elderly individual from an acute care setting who is provided an orientation program to an extended care facility by a registered nurse from that facility will experience more positive adaptation than an elderly individual from an acute care setting



who is not provided an orientation by a registered nurse from that facility.

2. An elderly individual from an acute care setting who is provided an orientation program to an extended care facility will demonstrate a higher level of social activity than an elderly person from an acute care setting who is not provided an orientation program.
3. An elderly individual from an acute care setting who is provided an orientation program to an extended care facility will demonstrate a higher level of knowledge regarding the facility's policies and procedures than an elderly individual from an acute care setting who is not provided an orientation program.

The hypotheses for this study were neither accepted nor rejected, as the researcher was unable to carry out the intervention due to lack of eligible participants for the study. Sixty-six individuals were admitted to the extended care facility over a four month period, but only eight individuals were eligible for participation in the study according to the study criteria. Of the eight individuals who were eligible upon admission for participation in the study, only three remained in the study at the time of the posttest. Of the three participants who remained eligible at the time of the posttest, one individual was a member of the experimental group and two were members of the control group. The number of participants was insufficient to report any significant findings.

Due to the findings of the study, an additional research question was raised relative to the characteristics of the population at the



skilled nursing facility. Therefore, permission was obtained from 22 subjects of the 66 individuals who were newly admitted to the newly admitted skilled nursing facility over a four month period to accomplish a medical record audit. The purpose of the audit was to describe the characteristics of the skilled nursing facility population. The results of the medical record audit were indicative of a population of elderly individuals who were ineligible for the experimental study related to the criteria. The findings of the medical record audit were that 12 of the 22 subjects had experienced one prior nursing home admission; five of the subjects were unable to communicate; seven subjects were discharged from the facility prior to one month post admission; three subjects were diagnosed with organic brain syndrome; and eight subjects were too physically debilitated to participate. These data were characteristic of one-third of the elderly population who were being admitted to the skilled nursing facility over a four month period. All of the individuals who were described were admitted to the skilled nursing facility from the acute care setting.

Of the total 30 subjects studied, eight subjects from the original experimental study were described based upon the pretest data. The eight subjects from the original study were also admitted from the acute care setting to the skilled nursing facility.

By describing 30 subjects who were transferred from the acute care setting to the skilled nursing facility, the researcher was able to identify several characteristics which have vital implications for

long-term care and which guide recommendations for future research related to relocation of the elderly to long-term care institutions.

Recommendations

Recommendations for Future Research

In lieu of the design in this research study, an alternate type of design would be recommended for future research regarding the topic of relocation of the elderly from the acute care setting to the extended care setting. Initially a pilot study would be appropriate which would describe the population which is being admitted from the acute care setting to the extended care facility. The population which would be described could be composed of those elderly individuals who were currently in the acute care setting who were to be placed in an extended care facility. By identifying the population at the acute care setting, the acuity level of the patient could be ascertained prior to the relocation so that the orientation program to the extended care facility could be planned according to the patient's capability. Also, by obtaining the study sample at the acute care setting, the researcher would be able to follow the individuals to several different facilities rather than to only one facility as in this study.

After assessing the population in the acute care setting during the pilot study, it would be determined whether or not the population was variable and whether or not there were a significant number of eligible participants so that it was feasible to attempt a descriptive study. If it was feasible to attempt a descriptive



study, it is recommended that all elderly individuals in the acute care setting who were being transferred to an extended care facility be provided an orientation program to prepare them for the move. The content of the orientation program would be dependent upon the type of facility to which the individual was being transferred. However, all individuals who participated in the study would be screened utilizing a standardized Sociodemographic Questionnaire.

Criteria for Future Study

The criteria for the study should be less restrictive in regard to mobility status, mental status, and communication status. Also, the subjects who had experienced previous admissions to an extended care facility should be eligible for participation since every new admission for the individual is a new experience and those individuals would also benefit from an orientation program.

The study criteria related to each participant staying at the facility for at least one month would not be necessary. The purpose of the study would be to observe the individual's adaptation post-relocation to the new facility, and duration of stay would not be a criterion.

The necessary criteria for the study would be:

1. The subjects would be transferred from the acute care setting to the extended care facility.
2. The subjects would be 55 years of age or older.
3. The subjects would voluntarily agree to participate and cooperate in the study and would be willing to participate upon request in a brief orientation program to introduce him/her to the

facility. In the event that the subject was diagnosed as having organic brain syndrome, Alzheimer's disease or dementia or was unable to communicate and was unable to respond to the screening items on the Sociodemographic Questionnaire, a family member/significant other could be identified who was responsible for their care and that individual would participate in the study.

The criteria for future study of elderly individuals who are relocated from the acute care setting to the extended care facility would be less rigid than the criteria proposed in this study. The orientation program would be also less rigid and more individualized.

Orientation Program

After identifying the population at the acute care setting with the assistance of the social services department regarding those elderly patients who were being transferred to an extended care facility, the researcher could implement the orientation program. The orientation program would be implemented before the elderly individual was discharged from the acute care setting. The orientation program would include familiarizing the patient and/or family with the extended care facility and answering any questions which the patient and/or family raised regarding the transfer. Part of the preparation for the move would involve provision of a familiar person i.e. the researcher who would be available to the patient and/or family both prior to the move and post-transfer to provide continuity and support throughout the relocation experience.

In order to accomplish the change in design so that the patients and/or families could be prepared prior to the relocation at the acute care setting, the researcher would be required to obtain permission from all of the involved facilities in order that he/she could accomplish the research. However, although it would be a greater task to gain entry into several facilities than it would be to function at one facility post-relocation as was done in this study, the opportunity for gaining greater participation in the study would occur.

It is recommended that the research question or problem statement could remain the same as the question which was identified in this study if the focus of the prior preparation for the move became the acute care setting instead of the extended care facility. The question would remain as: "What is the effect of an orientation program by a registered nurse from an extended care facility upon an elderly individual's adaptation to that facility upon being admitted from an acute care setting?" The change in preparation for the relocation experience from the extended care facility to the acute care setting would change the timing of the orientation program but not the measurable outcome. The outcome which would be measured would be adaptation.

The patient's adaptation was to be measured in terms of knowledge and social activity in this study, but due to the attrition rate, the measurements were never obtained. Therefore, it is recommended for future research that knowledge and social activity are measured as indicators of level of adaptation. However, instead of measuring the

individual's knowledge and social activity post-relocation at a facility in which the level of acuity of care of the newly admitted patients was extremely high, it is recommended that the individuals are screened utilizing the Sociodemographic instrument while in the acute care setting. By screening the individuals at the acute care setting, the chances of the level of acuity being more variable would increase and therefore the number of eligible participants could increase. The variability in the level of acuity of the patients would be determined in the initial pilot study describing the population of elderly individuals in the acute care setting who were being discharged to extended care facilities.

The functional level of the participants in the study would be determined and the orientation program would be based on the acuity level of the patient. The ambulatory individuals and more mobile individuals would participate actively in a tour of the facility whereas the less mobile patients would view a videotape of the facility layout. The most severely impaired individuals, both mentally and physically who met the study criteria would be provided a simple orientation program and/or their family member/significant other would participate in the orientation program. Family members/significant others of all participants would be encouraged to participate in the orientation program.

It is recommended that those elderly individuals in the acute care setting who met the screening criteria would be given a knowledge pretest within the first week of discharge from the acute care setting and the Short Portable Mental Status Questionnaire

(SPMSQ) would also be administered. The knowledge questionnaire and the SPMSQ would be repeated at posttest one month post admission or at discharge from the facility whichever occurred first. The purpose of the SPMSQ would be to evaluate mental status prior to admission and then to observe for any changes at posttest. The mental status assessment at pretest and posttest would possibly address the issue of mental status changes over time which could potentially impact the participant's performance on the knowledge questionnaire or upon his/her social activity over time. The individual's mental status could potentially influence the individual's adaptation to the new setting.

The knowledge questionnaire would be scored by summation of incorrect responses and reporting of the number of incorrect responses out of a total possible score. The number of correct responses by each participant in the group would be recorded and pretest to posttest differences would be compared in order to describe the effectiveness of the orientation program.

The social activity of the individuals who were relocated to the extended care setting would be monitored from admission to one month post-admission. The number of formal and informal social contacts would be recorded.

The Social Activity Record would be scored at one month post-admission by tallying the number of times the patient participated in formal social activities in a one month period. The number of times each participant attended formal social activities would be recorded and pretest to posttest differences would be

compared. The results would be compared and differences noted in order to describe the effectiveness of the orientation program.

Social activity would also be evaluated by logging the social worker's and the charge nurse's assessment of the patient's social activity. The social worker's notes would be checked and the patient's social activity would be noted. The charge nurse's perception of the amount of social activity experienced by the participants would also be recorded. The researcher would interview the charge nurses and record their perceptions and observations regarding the types of social activities in which the study participants would be involved.

The social worker's and charge nurse's reports and comments, and the recording on the formal activity record would provide an overall picture of the participant's social activity to include 1) participation in formal social activities and 2) participation in informal activities i.e. family visitation, visitation by other residents of the facility. The amount of participation could be measured and scored on a Likert-type scale with a scoring of (0-10) little social activity to (20 +) a great deal of social activity.

Social activity varies from individual to individual and the researcher should note the amount and type of social activity in which the individual was involved prior to institutionalization. The former pattern of social activity could be noted in a brief statement after obtaining the social activity history from the participant and/or his/her family/ significantly other. In order to describe and compare social activity of several elderly individuals, it is

important to allow for individual differences and to describe those differences upon reporting the study findings.

Another important issue related to amount of social activity is to be sure to note physical limitations of the individual, i.e., acuity of illness, sensory/perceptual deficits. In order to accurately describe and compare social activity as an indicator of successful adaptation, it is important to correlate and/or describe the types of physical limitations which may hinder participation in social activity by an elderly individual.

The adaptation of the study participants could be described utilizing the data related to knowledge about the facility pretest to posttest and amount of formal/informal social activity experienced by the participants. Data analysis would include mean scores and frequencies related to social activity and t-tests related to pretest to posttest differences in knowledge about the facility.

Correlations could also be done utilizing alpha coefficients relative to comparison of mediating factors to the results i.e. severity of illness, mental status, age, functional status and family support. The mediating factors which significantly affected the study results would be reported with $p < .05$.

It is recommended for future research that an experimental study related to interinstitutional relocation of the elderly from the acute care setting to the extended care setting is to be attempted only after: 1) a pilot study is accomplished to determine the feasibility of this type of study and 2) a descriptive study of the issue is accomplished in order to describe the population and to

determine the effectiveness or ineffectiveness of an orientation program. If the orientation program can be described as significantly effective for elderly individuals who are relocating from the acute care setting to the extended care facility, an experimental study could be designed to test the effectiveness of an orientation program.

The effectiveness of the orientation program would be measured by the experimental group's performance on the knowledge questionnaire compared to the performance of the control group. Also, the amount of social activity recorded for the members of the experimental group compared to the amount of social activity of the control group, taking into account individual differences, would determine the effectiveness of the orientation program and, thus, the patient's adaptation to the extended care facility would be determined.

One question which was raised during the course of this study which should be pursued is: "What role does the family/significant other play in the elderly individual's adaptation post-relocation upon being transferred from the acute care setting to the extended care facility?" It is recommended that this issue should be pursued in any future studies related to interinstitutional relocation of the elderly. By measuring the individual's informal social activities, the family or significant other's visits will be documented. Also the charge nurse's and social worker's perceptions of the elderly person's social activity will provide information regarding social contacts by the family and/or significant other(s). However, the question of the role of the family and/or significant other(s)



related to the patient's adaptation post-relocation should be pursued in greater depth. The family/significant other(s) should be interviewed and areas related to relationships, decisions, influence, financial assistance and past caregiving should be addressed.

Due to the limitations of this study related to recruitment of adequate numbers of participants after a four month period of study, the recommendations which have been made for future research are to attempt to redesign the study so that a significant number of participants may be recruited. Also, the recommendations include a stepwise approach to the experimental design in lieu of starting with an intervention study without piloting for feasibility. Lastly, it is recommended that the family and/or significant other's involvement related to impact upon the individual's adaptation should be pursued.

Recommendations for Nursing Practice

The concept of relocation related to moving the elderly from one place to another has been discussed in the literature at great length over several years. The only conclusion which has been agreed upon in the findings is that prior preparation to the move is a key factor in an elderly individual's positive adaptation to the move. The implications for nurses related to the issue of prior preparation to the move are that the professional nurse is in a key position to provide the prior preparation for the move to the client. Therefore, it is recommended that professional nurses who practice in both acute care and extended care settings could play a major role in assisting an elderly individual and family in the relocation experience from



acute care to extended care. An increase in communication between the nurses in acute care and extended care is needed in order that each one understands the other's setting. By understanding the operation of each type of setting regarding routines, policies and procedures, the patients can be prepared prior to moving from one environment to the other. Also, if the extended care facility nurses are more familiar with the acute care setting, they will have an increased understanding of the patient's experiences prior to relocation. The extended care facility nurses can also assist the patients who are newly admitted to the extended care setting post-relocation by providing information about the facility, its policies and procedures and daily routines. The extended care facility nurses can also perform a functional assessment on each patient who is newly admitted and determine his/her plan of care based upon nursing diagnoses, goals for treatment and expected outcomes.

Based upon the data which was retrieved from the medical record audit, the nurses in both acute care and extended care settings can expect that the patients with whom they work will be more acutely ill than in the past several years due to DRG's, and they will present to the extended care setting after a shorter acute care stay. The elderly patients in this study had multiple care needs upon admission to the skilled nursing facility and were fairly dependent in most cases. Therefore, it will be very important to develop a comprehensive plan of care upon the first day of admission and to continue to update the plan of care as the patient's condition



changes. Ongoing assessment from the time of admission to the acute care setting which could be communicated to the skilled nursing facility would be a most comprehensive means of caring for the elderly individual and "bridging the gap" throughout the relocation process.

Another recommendation for nursing practice is to incorporate the concept of an orientation program for all elderly patients who are being discharged from the acute care setting or for those elderly individuals who are being admitted to the extended care facility into the discharge and/or admission policies respectively. If prior preparation for the move was a routine procedure upon discharge from the acute care setting and if an orientation program was presented by the nursing staff to each newly admitted elderly individual and their family or significant other, preparation for relocation could become a policy and procedure from which all elderly individuals would benefit.

Discharge planning nurses who would participate in preparation for relocation to alternative living environments, i.e., extended care facilities would be in a strategic position to impact the elderly individual's relocation experience. Creative techniques, i.e., video cassette recordings of the routines and surroundings of the facility which the patient is transferring to and brochures which are designed to describe the policies and routines of the extended care facility could be implemented.



Relationship to Theoretical Model

In order to relate theory to practice regarding the relocation of the elderly individual from the acute care setting to the extended care setting, the conceptual framework for this study could be utilized to direct the acute care and extended care nurse's interventions. The elderly patient who is being relocated could be assessed regarding inputs, i.e., his/her feelings regarding the move; his/her reaction to the family and staff's attitudes about the move; the physical effects of the move and the patient's mental status at the time of the move. The nurses in both settings could then plan the individual's care and observe measurable outcomes, i.e., mood, demands for attention, confusion, appetite, mobility status, etc. The nurses could manipulate the stimuli through further nursing interventions to work toward positive outcomes for the patient.

Nursing Education

In regard to nursing education, there are several opportunities for the professional nurse to provide input into the elderly individual's relocation experience. Nursing educators could initiate the education of professional nurses regarding relocation of the elderly. Relocation and its effects upon the elderly population could be presented in the didactic portion of the student nurse's course work, and the theory related to relocation of the elderly and its effects could be operationalized in the clinical portion of the nurse's education experience.

The recommendations for nursing education based upon the content of this study are that nurses could be introduced to the concept of

relocation of the elderly during their educational experience and could incorporate that knowledge as a part of routine practice when working with the elderly who are being relocated. Programs regarding relocation of the elderly could be presented in educational seminars for the nursing staff of both acute care and extended care settings. Workshops regarding the issue of relocation of the elderly could also be presented in the community for professionals and non-professionals who are involved in caring for the elderly.

Nursing leaders could reinforce the need for support for the elderly and their families/significant others during the relocation experience through seminars and workshops. Nurses who are employed by institutions in health care which deal with the care of the elderly could be very influential in impacting facility or institutional policies and procedures related to nursing care of the relocated or soon to be relocated elderly.

Nursing Service

Implications for nursing service related to relocation of the elderly and prior preparation for the move can be identified as: 1) impacting policy-making related to relocation issues; and 2) enforcement of policy which has been set related to relocation of the elderly. Other service-related issues regarding relocation of the elderly involve community awareness related to the impact of relocation upon the elderly and provision of information to non-nursing disciplines who are involved with care of the elderly.

Implications which the results of this study have for nursing practice, education and service have been identified as practical



measures which any professional nurse could utilize in any setting regarding preparation of the elderly individual for a relocation experience. Creativity in formulating means to assist the elderly is imperative in order to address the multiplicity of physical disabilities versus learning needs of the elderly population.

Implications for Advanced Practice in Nursing

There are also implications in nursing related to the nurse in advanced practice related to relocation of the elderly. The implications for the advanced nursing practitioner in primary care are related to the many role characteristics which are identified in the advanced practitioner's role. The implications which are indicated as a result of this study related to the Clinical Nurse Specialist's role in relocation of the elderly are that the Clinical Nurse Specialist will function as:

1. An assessor collecting subjective and objective data related to the individual who is being relocated in order to form a data base to assist in the formation of tentative nursing diagnoses which may impact the relocation experience. The Clinical Nurse Specialist will initiate the assessment and work with the client in the primary care setting.
2. A change agent utilizing relocation theory and the findings in the literature related to relocation of the elderly and prior preparation for the move in order to impact policy/procedural issues. The Clinical Nurse Specialist can function to provide education and anticipatory guidance related to relocation of the elderly in the primary care setting as a part of an examination.

3. A client advocate by working with the client and/or family to promote a more positive relocation experience.
4. A clinician in formulating nursing diagnoses and managing disabilities or difficulties related to the relocation experience. Also, the Clinical Nurse Specialist in primary care will function as a clinician in collecting data to determine the need for relocation for an elderly client.
5. A collaborator working with the physicians, social workers and other members of the health care team in effecting the relocation of the client. The Clinical Nurse Specialist can collaborate with the primary care team when a determination for relocation for an elderly client is necessary.
6. A consultant to the acute care or extended care nursing staff or other health professionals regarding interinstitutional relocation and its impact upon the elderly as well as functioning as a consultant to nurses and other professionals in the primary care setting.
7. A coordinator by facilitating and coordinating the interinstitutional move for the elderly individual and family.
8. A counselor to the client and/or family regarding concerns related to the relocation experience especially in the primary care setting as primary or secondary prevention for the experience.
9. An educator to the community, to other nursing professionals, and to other health care professionals regarding interinstitutional relocation of the elderly.



10. An evaluator who appraises the effectiveness of the program which is designed to assist the elderly client and/or family in the relocation process.
11. A leader by directing others and facilitating the preparation of the elderly individual for the relocation experience. The Clinical Nurse Specialist also can function as a leader in primary care by introducing the concept of relocation and its impact upon the elderly.
12. A planner by developing a plan or program related to ways in which to deal with the relocation of the elderly individual which are more supportive than the current practice in primary care and also to plan ways in which to inform the community regarding the issue of relocation of the elderly and its impact especially as related to the effects on the family and/or significant others.
13. A role model to others in the way in which he/she deals with the client, family, and staff regarding the issue of relocation.
14. A researcher/inquirer by pursuing further study regarding interinstitutional relocation of the elderly in order to advance nursing knowledge. Also, by presenting the findings of this research study at professional nursing seminars.

Therefore, since the results of the study were unable to be analyzed due to the lack of study participants, it is imperative that further research is pursued regarding relocation of the elderly and more specifically interinstitutional relocation of the elderly. Due to the findings in the literature related to the importance of prior

preparation for a move when relocating the elderly, several implications were identified related to nursing theory, education, practice and service. Since DRG's have become an additional concern regarding more rapid discharge of elderly individuals from the acute care setting with less time for adequate preparation for the move, it is important that nurses are aware of the implications related to their role in moving the elderly from one setting to another.

Implications for the Clinical Nurse Specialist in caring for the elderly, other than those which are specifically related to operationalizing the role characteristics, are related to the Gerontological Clinical Nurse Specialist having more knowledge about issues in caring for the elderly than other health care professionals. The Clinical Nurse Specialist has more knowledge of resources which are available to the elderly individual in assisting them with relocation. The Clinical Nurse Specialist can provide the elderly individual with available options for placement post-institutionalization and can assess the elderly individual and plan with him/her regarding the best alternatives for living arrangements related to their situation. Primary care placement opportunities for the elderly individual, i.e., Adult Foster Care, Home Care or Congregate Living can be recommended as alternatives to nursing home placement whenever feasible.

The Clinical Nurse Specialist in Primary Care can also provide education, family support and continuity of care in providing care to the elderly individual and/or family who is faced with relocation. Mobilization of resources can also be accomplished by the Clinical



Nurse Specialist in the primary care system in order to look at the whole person rather than the physical defects only.

In the long-term care arena, the Clinical Nurse Specialist can recommend alternative types of placement, provide education and mobilize resources, and can also listen to the client's concerns and work with the nursing staff to inform them of the client's needs. If the Clinical Nurse Specialist is working in the nursing home setting in long-term care, the staff can be made aware of the acuity of care required by the elderly client(s) and can assist in preparing the nursing staff and the families.

Physicians and other health care professionals can be assisted by the Clinical Nurse Specialist in Primary Care regarding concerns related to appropriate care for the elderly regarding relocation issues. In the event of nursing home placement, the Clinical Nurse Specialist in Primary Care can assist physicians and other health care professionals to understand how the system works, i.e., the requirements imposed by regulatory agencies, the policies and procedures of the institution, the alternatives which are available in the event that the elderly individual is discharged from the nursing home setting.

Regarding discharge from the nursing home setting, the Clinical Nurse Specialist can begin discharge planning with the client soon after admission if appropriate, and can share with the client and/or family the percentage of individuals who go home from the facility. The Clinical Nurse Specialist could plan and contract with the client and/or family to go home or to an alternative living arrangement.



Based upon the data from this research, it was noted that 23% of the elderly individuals who were admitted to the facility were discharged to their home or to alternative living arrangements. Therefore, it is important to note that persons do go home and inform clients and families that the nursing home setting is not necessarily the final placement alternative.

The Clinical Nurse Specialist in Gerontology can utilize a conceptual framework such as the one utilized in this study upon which to base his/her practice in the care of the elderly who are experiencing interinstitutional relocation. Based upon such a model the issues which are related to interinstitutional relocation of the elderly can be explored and interventions can be planned with the client, family and/or significant other utilizing the expertise of the Clinical Nurse Specialist. The Clinical Nurse Specialist is the primary gatekeeper in affording the client the most continuous, comprehensive and coordinated care possible given the circumstances surrounding the relocation event.

Conclusions

The following conclusions have been formulated as a result of the findings of this study:

1. It was not feasible to complete an orientation program for elderly individuals who were relocated from the acute care setting to 167 bed extended care facility in the Midwest due to the acuity level of the individuals who were being admitted to the facility and to the number of individuals who were residents



of an extended care facility prior to admission to this facility so that the individuals failed to meet the study criteria.

2. It was not possible to investigate the effects of relocation on an elderly individual's ability to adapt to the new environment when moving from the acute care setting to the extended care facility due to the lack of participants.
3. It was not possible to ascertain the effectiveness of the orientation program which was designed in this study upon the newly relocated patient's adaptation to the 167 bed extended care facility due to the lack of participants.
4. It was possible to describe the characteristics of the newly admitted elderly population in a skilled nursing facility.

Discussion of Conclusions

The conclusions which have been drawn from the findings of this study are directly related to the original purposes which were identified for the study. The original purposes were not met due to the lack of eligible study participants. The effectiveness and feasibility of an orientation program by a registered nurse from an extended care facility could not be ascertained during the course of this study nor could the elderly individual's adaptation post-relocation be measured. The acuity level of the patients who were admitted over the four month period of study was high and only eight participants out of 66 newly admitted patients were eligible for the study according to the study criteria. Of the eight eligible participants, three participants were available at posttest to complete the study.

The hypotheses for the study were neither accepted or rejected due to the lack of participants. It was not possible for the desearcher to determine whether or not:

1. An elderly individual from an acute care setting who is provided an orientation program to an extended care facility by a registered nurse from the facility will experience more positive adaptation than an elderly individual from an acute care setting who is not provided an orientation by a registered nurse from that facility.
2. An elderly individual from an acute care setting who is provided an orientation program to an extended care facility will demonstrate a higher level of knowledge regarding the facility's policies and procedures than an elderly individual from an acute care setting who is not provided an orientation program.
3. An elderly individual from an acute care setting who is provided an orientation program to an extended care facility will demonstrate a higher level of social activity than an elderly person from an acute care setting who is not provided an orientation program.

According to the literature (Pastalan & Bourestrom, 1977; Petrou & Obenchain, 1987; Pino et al., 1978; Kennedy et al., 1987; Mirotznik & Ruskin, 1984) prior preparation for the move i.e. provision of an orientation program for elderly individuals who are relocating from one institution to another provides for a more positive adaptation. Therefore, the literature is supportive of the original intent of this study which was to determine the feasibility

and effectiveness of an orientation program upon the elderly individual's adaptation post-relocation. The literature was found also to be in favor of the hypotheses of this study which indicated that the elderly individuals who were involved in an orientation program post-relocation would experience more positive adaptation than those who did not. However, since the study was not completed as designed due to lack of participants, the hypotheses can neither be supported nor rejected.

The literature related to relocation of the elderly and orientation programs for the elderly who are being relocated did not contain evidence of relocation of the elderly from the acute setting to the extended care facility since the advent of DRG's (diagnosis-related groups). Therefore, it was not possible to rely on the studies in the literature regarding the outcome of this experimental study as there are few similar studies which have been reported.

It has been recommended in this study that due to the support in the literature for the issue that an orientation program prior to the move can be a positive experience, a study could be designed to obtain participants at the acute care setting. The study would be designed to screen the potential subjects at the acute care setting in order that a more variable population could be identified compared to the limited population which was identified at one skilled nursing facility in this study.

In planning the orientation program at the acute care setting, issues such as (1) client expectation regarding the move, (2) forced

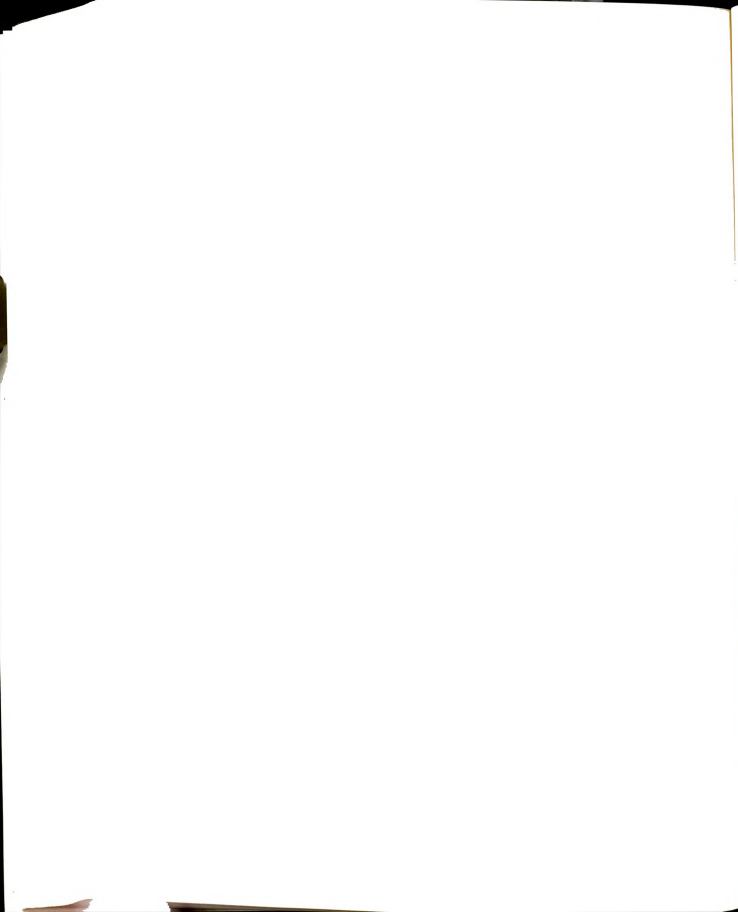


choice, and (3) client's sense of control relative to the move should be taken into consideration. The client's expectation(s) about the move can be ascertained upon interview of the client or upon initial assessment. The client's questions and/or concerns can be answered and the client and/or family/significant other can participate in a mutual planning process.

The client's feelings regarding relocation as a "forced choice" issue could also be explored upon initial assessment. The "forced choice" issue can be discussed with the client and/or family/significant other and the client can become a part of the planning process in order that he/she and/or his family/significant other do not feel as though they are being forced into the relocation.

The client's sense of control relative to the move is of vital importance in the relocation process, and by identifying areas in which the client/family/significant other can make choices related to the move, they can feel more a part of the process. The interventions dealing with control or "forced choice" issues may be as simple as listening to the client's or family's concerns and keeping them informed regarding the relocation process.

Most of the studies in the literature (Pastalan & Bourestom, 1977; Petrou & Oberchain, 1987; Pino et al., 1978; Kennedy et al., 1987; Mirotznik & Ruskin, 1984;) were performed utilizing an orientation program prior to the relocation experience as compared to the orientation program which was to be offered in this study within 48 hours of admission to the skilled nursing facility. Therefore, it has been recommended by this researcher that the original intent



and/or purposes of the study remain the same, but the design could be rewritten and a study could be carried out at the acute care setting as the initial site for screening potential subjects and implementing the orientation program.

Theoretical Implications

The hypotheses in this study were neither supported nor rejected and therefore the findings are not identifiable as lending strength or modifying existing theory. However, since the restrictiveness of the study criteria combined with the high acuity level of the newly admitted patients were the main factors which minimized eligibility for the study, if the study was replicated utilizing the acute care population in conjunction with a new design, the opportunity for completion of the study is a feasible one.

The variables in a replication study regarding relocation of the elderly from acute care to extended care would remain as knowledge and social activity as indicators of the variable of adaptation. Additional concepts which would be discussed in a replication study would be functional status of the participants, involvement of family and/or significant others and social support.

The theoretical implications related to the idea for a replication study with a modified population and modified design are that relocation of the elderly is viewed by this researcher as a major life event which could be explored more fully. Also, since there is a strong indication in the relocation literature that prior preparation for the move, i.e. orientation programs, are supportive and assistive measures which can be implemented to assist the elderly

individuals to experience more positive adaptation upon relocation, further research related to the topic should be pursued. According to Mirotznik and Ruskin (1984) "it is imperative that we continue to expand our knowledge to better understand the consequences of relocation for the elderly" (p. 26).

With the advent of DRG's (diagnosis related groupings) it is imperative that the issue of relocation of the elderly be examined further. Due to shorter acute care stays and earlier discharge, the elderly are being relocated more rapidly from the acute care setting to alternative living arrangements to include extended care facilities. Since most of the studies related to relocation of the elderly which were cited in this study were completed prior to the advent of DRG's, it is important that further studies are accomplished which describe the situation and add to the literature regarding feasible intervention and/or proposals related to interinstitutional relocation of the elderly.

Study Contributions

The contributions which this study has made to the concern regarding relocation of the elderly from the acute care setting to the extended care facility are:

1. The identification of a low success rate related to orientation of the elderly individual at post-relocation.
2. The realization that the family and/or significant other(s) must be targeted in preparation for the move in the event that the elderly individual is unable to participate or cooperate in the move.



3. The recognition that shorter acute care stays are creating a need for prior preparation for the relocation to the extended care facility as soon as possible at the acute care setting.
4. The identification of a need for a pilot study regarding the issue of relocation of the elderly in order to better define the problem.
5. The notion that increased severity of physical status requires increased acuity of nursing care which identifies a need for increased nursing staff, especially an increase in registered nursing coverage on a 24-hour basis.
6. The recognition that there is a need for multidisciplinary intervention and collaboration in order to address the multiplicity of needs of the institutionalized elderly.

The issues of concern in the nursing profession related to the relocation of the elderly from one institution to another are becoming more visible, but more up-to-date research is needed in order to more clearly define the problem. Also, more research is needed as has been indicated by this study in order to assist others regarding design and methodology which is workable when addressing the issue of interinstitutional relocation of the elderly.



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APPENDICES

APPENDIX A

Socioeconomic and Demographic Questionnaire



Socioeconomic and Demographic Questionnaire

1. Date: _____
2. ID #: _____
3. Birthdate: _____ Age: _____
4. Sex: ☐ Male ☐ Female
5. Marital Status: ☐ Single
☐ Married
☐ Widowed
☐ Divorced
☐ Separated
6. Ethnic background (optional): (CHECK MORE THAN ONE IF APPLICABLE)
- ☐ Caucasian
☐ Hispanic
☐ Afro American
☐ Native American
☐ Other
7. Languages spoken (check one): ☐ English
☐ French
☐ Spanish
☐ Other (please specify _____)
8. Education level (highest grade completed):
- ☐ Elementary school (0-6th grade)
☐ Junior High School (7 - 9th grade)
☐ Some high school
☐ Completed/graduated high school
☐ College (number of years attended: _____)
9. Religion (check one): ☐ Protestant
☐ Catholic
☐ Other (please specify _____)
10. Employment status:
- Place of employment (currently or formerly _____)
- Job title: _____
11. Chronic illnesses: 1. _____
2. _____
3. _____

12. Number of prior hospitalizations in past five years (1981-1986):

☐ 1-5
☐ 6-10
☐ 7-15

13. Number of prior nursing home admissions: ☐ 0
☐ 1
☐ 2

14. Familiarity with nursing home procedures:

☐ Not familiar at all
☐ Familiar (have been a resident of nursing home before)
☐ Familiar (have had a family member in a nursing home)
☐ Familiar (have visited a nursing home)
☐ Familiar (have been told about this nursing home)
☐ Familiar (have toured this nursing home)
☐ Familiar (the Director of Nursing has visited me prior to my admission here)
☐ Unfamiliar (have never visited or been in a nursing home and know very little about nursing homes)

DO NOT WRITE BELOW THIS LINE

15. Medical insurance: ☐ YES ☐ NO

Type(s): _____

16. Responsible party name: _____

Relationship: _____

17. Medical diagnosis (current): _____

18. Name of facility transferring to: _____

Expected length of stay (number of days): _____

10/20/86

APPENDIX B

Short Portable Mental Status Questionnaire (SPMSQ)

Pfeiffer
Short Portable Mental Status Questionnaire (SPMSQ)

INSTRUCTIONS: Ask the subject questions 1-10, record answer, and enter as "1" under appropriated column (correct/error). All responses to be scored correct, must be given by subject without reference to calendar, newspaper, birth certificate or other memory aid.

- CORRECT ERROR
1. What day is it?
 Month _____ Day _____ Year _____
 (Score correct only when the exact month, day year are given correctly.)

2. What day of the week is it? Day _____

3. What is the name of this place?

 (Score correct if any correct description of the location is given: "My home," accurate name of town, city, or name of residency hospital, or institution (If subject is institutionalized) all are acceptable.)

4. What is your telephone number?
 (If none, see 4A below.)

 (Score correct when the correct number can be verified or when subject can repeat the same number at another point in questions.)

- 4a. What is your street address? (Ask only if subject does not have a telephone.)

5. How old are you? Age _____
 (Score correct when stated age corresponds to date of birth.)

6. When were you born?

Month _____ Day _____ Year _____
 (Score correct only when exact month, date and year are all given.)

7. Who is the president of the United States now?

 (Only the last name of the president is required.)

8. Who was the President before him?

 (Only last name of previous President.)

9. What is your mother's maiden name?

(Does not need to be verified. Score correct if female name plus last name other than subject's last name is given.)

10. Subtract 3 from 20 and keep subtracting 3 from each new number all the way down?

(The entire series must be performed correctly in order to be scored correct. Any error in series or unwillingness to attempt series is scored as incorrect.)

TOTAL ERRORS _____

Adjustment Factors:

- A) Subtract 1 from ERROR SCORE if subject has had only a grade school education. - _____
- B) Add 1 to ERROR SCORE if subject has had education beyond high school. + _____

TOTAL ADJUSTED ERRORS _____

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APPENDIX C
Knowledge Questionnaire

Knowledge Questionnaire
(Ten Items)

CORRECT ERROR

1. Identify two of the rights which patients have at this facility according to the Patient Bill of Rights?
2. What are the visiting hours at this facility?
3. What departments other than the nursing department provide services for the residents of this facility? (List two.)
4. How do you obtain the services of a dentist or a foot doctor if you need them?
5. How do you obtain the services of a beautician or barber if you need them?
6. Where is the beauty/barber shop located?
7. What type(s) of social activities are available at this facility? (List three.)
8. Where are the group social activities held?
9. What time are your meals served?
10. What time are medications administered (given) by the nurse?

TOTAL _____

10/20/86

APPENDIX D
Social Activity Record

[illegible]

APPENDIX E

Chart Review Form

Chart Audit Review Form

CHART AUDIT/REVIEW FORM

Events or condition changes which may effect the resident's relocation experience:

Social Changes or EventsYESNO

1. Presence of family support?

(Number of visits per week? ___)

2. Discharge plans in place?

3. Moved from one room to another?

4. Room rate changed occurred?

5. Death of a loved one?

6. Private duty nurses present?

7. Attends therapy:

--Physical

--Occupational

--Speech

8. Social worker involvement on a regular basis?

Physical Changes or Events

1. Infection (s)? (number ___)

2. Pain?

3. Bleeding

4. Medication reactions? (number ___)

5. Falls? (number ___)

6. Post-operative complications?

7. Complications of bed rest?

8. Change in level of responsiveness?

Describe: _____

9. Alteration in nutrition?

Describe: _____

APPENDIX F

Routine Services Guide

VISITING HOURS: 11:30 AM - 1:00 PM

DAILY ROUTINES:

1. Medications are given by the nurse at
9:00 AM - 1:00 PM - 5:00 PM - 9:00 PM

2. Mealtimes are:

Breakfast 7:00 AM
Lunch 12:00 Noon
Supper 5:00 PM

3. Bedtime activities are:

Bedtime 9:00 PM - 10:00 PM
Snacks 8:00 PM

ACTIVITIES/SERVICES WHICH ARE AVAILABLE

	WHEN	WHERE
Recreational Activities	Times are Posted	2nd Floor Dining Room
Beauty/Barber Shop	Weekdays	3rd Floor
Library	Weekdays	From Activity Director
Consultants (Foot Doctor, Dentist, Psychiatrist)	As Needed	See Charge Nurse

ANCILLARY SERVICES

Supervisor's Name	Location
Housekeeping/Laundry	Ms. C. Stubbs Basement
Dietary	Mrs. M. Durbin 1st Floor
Maintenance	Mr. B. Metiva Basement

APPENDIX G

Human Subjects

MICHIGAN STATE UNIVERSITY

UNIVERSITY COMMITTEE ON RESEARCH INVOLVING
HUMAN SUBJECTS (UCRIHS)
238 ADMINISTRATION BUILDING
(517) 355-2186

EAST LANSING • MICHIGAN • 48824-1046

December 2, 1986

Ms. Janet Elgood
College of Nursing
A230 Life Sciences Building

Dear Ms. Elgood:

Subject: Proposal Entitled, "The Effects of Orientation to an
Extended Care Facility on the Elderly Person's
Adaptation to the Patient Role"

UCRIHS' review of the above referenced project has now been completed. I am pleased to advise that the rights and welfare of the human subjects appear to be adequately protected and the Committee, therefore, approved this project at its meeting on December 1, 1986.

You are reminded that UCRIHS approval is valid for one calendar year. If you plan to continue this project beyond one year, please make provisions for obtaining appropriate UCRIHS approval prior to December 1, 1987.

Any changes in procedures involving human subjects must be reviewed by the UCRIHS prior to initiation of the change. UCRIHS must also be notified promptly of any problems (unexpected side effects, complaints, etc.) involving human subjects during the course of the work.

Thank you for bringing this project to our attention. If we can be of any future help, please do not hesitate to let us know.

Sincerely,


Henry E. Bredeck, Ph.D.
Chairman, UCRIHS

HEB/jms

cc: Dr. Barbara Given

MICHIGAN STATE UNIVERSITY

COLLEGE OF NURSING

EAST LANSING • MICHIGAN • 48824-1317

MEMORANDUM

October 16, 1986

TO: Henry Bredeck, UCRIHS

FROM: Barbara Given, Ph.D., R.N., F.A.A.N.
Director for the Graduate and Research Programs

RE: Janet Elgood

Janet successfully defended her thesis proposal. Her committee approved her proposed research project for her M.S.N. program in the College of Nursing.

/pla

APPENDIX H

Consent Forms



Dear

I am a graduate student in nursing at Michigan State University and I am conducting research at Kith Haven, Inc. My study involves reviewing the medical records/charts of those elderly individuals who are admitted to Kith Haven, Inc., from the hospital.

My goal in conducting this research is to determine how the elderly person who is transferred to the nursing home from the hospital adapts to such a change. Therefore, I would like to request that you give me permission to review your relative's/client's medical record. The time of review would involve a 30 day period, from admission until one month after admission. The medical record review would in no way affect your relative's/client's stay at Kith Haven.

If you are willing to grant permission to me to review your relative's/client's medical records for this research study, please sign the enclosed consent form and return it in the self-addressed stamped envelope.

Thank you for your consideration in this matter.

Sincerely,

Janet Elgood, R.N.
Graduate Student
Michigan State University

Enclosure

CONSENT FORM - MEDICAL RECORD AUDIT

By agreeing to participate in this study regarding the effects of an orientation program by a registered nurse to an elderly individual who is moving from a hospital to a nursing home, you will be giving permission to the researcher to review your relative's/client's medical record for the purpose of information retrieval. The information will be retrieved during the period from admission to one month after admission. If you agree to participate in this study, please sign the following statement.

By signing this form, I understand that:

1. I have freely given consent to take part in this study.
2. I am free to discontinue participation in the study at any time without penalty.
3. The information which is retrieved will be treated with strict confidence and all participants will remain anonymous.
4. I am not guaranteed any beneficial results from participation in this study.
5. Results of this study will be made available to me at my request.
6. This research is being conducted as partial fulfillment for the requirements for the degree of Masters of Science in Nursing, College of Nursing, Michigan State University.

Because of my relative's/client's medical condition, I realize that he/she may not be able to participate in this study. Therefore, I agree to sign on his/her behalf. Also, I understand that participation in this study will in no way affect his/her medical care.

Witness

Responsible Party Signature

Date

Date

CONSENT FORM

By agreeing to participate in this study regarding the effects of an orientation program by a registered nurse to an elderly individual who is moving from a hospital to a nursing home for the first time, you will be involved in answering two questionnaires and possibly participating in an orientation program within 48 hours of admission to the nursing home. Also, your participation will involve answering two questionnaires one month after admission to the nursing home. If you agree to participate, please sign the following statement.

By signing this form, I understand that:

1. I have freely consented to take part in this study.
2. The study has been explained to me. Furthermore, I understand the explanation that has been given to me and what my participation may involve.
3. I am free to discontinue my participation in the study at any time without penalty.
4. My responses on the questionnaires will be treated with strict confidence and all participants will remain anonymous.
5. I am not guaranteed any beneficial results from my participation in this study.
6. Results of this study will be made available to me at my request.
7. My medical record will be reviewed by the researcher for the purpose of information retrieval which relates to the study. The information which is retrieved will be reviewed and compiled by the researcher only.
8. This research is being conducted as partial fulfillment for the requirements for the degree of Masters of Science in Nursing, College of Nursing, Michigan State University.

Witness

Date

Signature

Date

In the event that the participant is unable to sign, the individual who is designated as the responsible party will sign.

Witness

Date

Responsible Party Signature

Date





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