



Complete Summary

GUIDELINE TITLE

Management of relocation in cognitively intact older adults.

BIBLIOGRAPHIC SOURCE(S)

Hertz JE, Rossetti J, Koren ME, Robertson JF. Management of relocation in cognitively intact older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2005 May. 63 p. [65 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Relocation and relocation stress syndrome

GUIDELINE CATEGORY

Management
Prevention
Risk Assessment

CLINICAL SPECIALTY

Geriatrics
Nursing

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Patients
Physician Assistants
Physicians
Social Workers

GUIDELINE OBJECTIVE(S)

- To provide strategies to help cognitively intact older adults (over 65) plan for and adapt to relocation from one residence or home to another
- To assist older persons in making prudent housing decisions and avoid crisis decision-making pre-relocation
- To promote adjustment after relocation to a new residence

TARGET POPULATION

Cognitively intact older adults (over 65) who are relocating

Note: The guideline excludes persons with a dementia-related diagnosis because their relocation needs and transitions differ from persons who are not diagnosed with dementia.

INTERVENTIONS AND PRACTICES CONSIDERED

Pre-Relocation

1. Preparing resources to work with relocating older adults
2. Assessing relocation needs
3. Planning the move
4. Individualizing the plan
5. Promoting coping while making a relocation decision
6. Assisting with pre-move preparation
7. Facilitating continuity of care

Post-Relocation

1. Tailoring of interventions to the older adult's personal values and preferences
2. Promoting personal sense of control and mastery
3. Providing social support and activities
4. Promoting coping with relocation
5. Orienting resident to the new living environment
6. Maintaining stability or continuity of care
7. Ensuring that physical and psychosocial needs are met

MAJOR OUTCOMES CONSIDERED

- Anxiety level
- Coping ability

- Depression level
- Loneliness severity
- Psychosocial adjustment
- Quality of life
- Client satisfaction
- Health status
- Participation in health care decisions
- Decision-making ability

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The grading schema used to make recommendations in this evidence-based practice guideline is:

- Evidence from well-designed meta-analysis
- Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g., assessment, intervention or treatment)
- Evidence from observational studies (e.g., correlational descriptive studies) or controlled trials with inconsistent results
- Evidence from expert opinion or multiple case reports

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Experts in the subject of the proposed guideline are selected by the Research Translation and Dissemination Core to examine available research and write the guideline. Authors are given guidelines for performance of the systematic review of the evidence and in critiquing and weighing the strength of evidence.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This guideline was reviewed by experts knowledgeable of research on management of relocation and development of guidelines. The reviewers suggested additional evidence for selected actions, inclusion of some additional practice recommendations, and changes in the guideline presentation to enhance its clinical utility.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of evidence (A-D) are defined at the end of the "Major Recommendations" field.

Assessment Criteria: Pre-Relocation

The following assessment criteria should be used to identify persons who are likely to benefit the most from use of this evidence-based guideline. Essential areas for assessment include: (a) the older adult's views and satisfaction with current living arrangement, (b) demographic characteristics, (c) current living arrangement, (d) current health status including mental health and prescribed therapeutics, (e) functional abilities and limitations, (f) sensory deficits, (g) availability of social

support and supportive services or caregivers to meet needs, and (h) recent life changes.

Assessment Tools, Instruments and Forms: Pre-Relocation

Assessment of older adults for relocation indicators should take place in community-based, acute care, and long-term care settings. For example, community-based settings can include physicians' offices, health departments, senior centers, and congregate housing units like senior apartments. Acute care settings and acute care encompasses care provided in hospitals, in rehabilitation units following an acute illness, or during skilled nursing visits by a home health nurse. Long-term care settings include assisted living facilities, traditional nursing homes, and continuing care retirement communities (CCRCs).

The assessment tool, Indicators of Need for Relocation Assessment Form (see appendix A.1 in the original guideline document), should be completed during the first encounter with the older adult. The assessment data should be validated and updated periodically. The frequency of assessment is determined on an individual basis. For example, in community-settings like physician's offices, the data should be validated during each office visit. In a congregate housing setting, the information should be updated every three to six months. In acute care settings, data should be updated more frequently as the person's condition changes. For example, daily updates can be made. In long-term care settings, validation every one to three months is needed. Reassessment is also indicated if there is a sudden change in the older adult's situation in life, such as the death of a spouse or caregiver, change in functional abilities, or acute occurrence or exacerbation of an illness. The Indicators of Need for Relocation Flowsheet (see appendix A.2 in the original guideline document) can be used to track the changes in these indicators.

Description of the Practice: Pre-Relocation

The interventions in the pre-relocation practice are aimed at assisting persons who exhibit pre-relocation indicators with their relocation decision-making. The primary focus is on application of the practice with the older adult, rather than with the older adult's family members. This practice can be implemented in community-based, acute care, and long-term care settings. The practice strategies apply to all of these settings unless indicated otherwise.

1. Prepare resources to work with relocating older adults. Prior to assisting older adults with relocation decisions, the designated health care provider should gather resources.
 - Assess the status of pre-relocation services in your community and develop a long-term care or housing information file for your community (Johnson & Tripp-Reimer, "Relocation among ethnic elders," 2001. *Evidence Grade = D*). Rural areas are more likely to have fewer resources (Cheek & Ballantyne, "Coping with crisis," 2001, "Moving them on and in", 2001; Magilvy & Congdon, 2000. *Evidence Grade = C*).
 - Gather information from senior services (e.g., American Association of Retired Persons [AARP], Area Agency on Aging, Senior Centers, Society on Aging) for assistance, direction, and information on housing

- alternatives and financial planning (Cheek & Ballantyne, "Coping with crisis," 2001. *Evidence Grade = C*).
- When working with ethnic older adults, educate self on key issues and develop relationships with key people in client's community. This will assist in developing therapeutic relationships with the relocating older adult (Johnson & Tripp-Reimer, "Aging, ethnicity, & social support," 2001. *Evidence Grade = D*).
 - In acute care settings, there should be a "nursing home liaison" position to help with the transition to the long-term care setting. Assign one liaison to each relocating patient and family (Cheek & Ballantyne, "Moving them on and in", 2001. *Evidence Grade = C*).
2. Assess relocation needs. Factors have been identified that determine to what type of residence the older adult will relocate. They include: (a) whether the older adult lives in an urban or rural area, (b) whether the decision is made in a crisis, (c) what resources are available, (d) the older person's socioeconomic status, (e) the older person's preference or choice, and (f) the older person's health status (Alcock et al., 2002; Holmes et al., 2003; Holmes, Krout, & Wolle, 2003. *Evidence Grade = C*). It is important for the provider to try to address each of these factors and to help the older adult find a residence that fits well with all five factors.
- Assess the older person's feeling regarding their current housing and the possibility of moving (Hays, 2002; Mitchell, 1999. *Evidence Grade = D*). How does the older person feel about relocation? What are the person's preferences, including cultural or ethnic preferences (Johnson & Tripp-Reimer, "Relocation among ethnic elders," 2001; Porter & Kruzich, 1999. *Evidence Grade = C*)? What are the older person's goals (Porter & Kruzich, 1999; Hays, 2002)?
 - Assess the older person's abilities, strengths, and coping strategies (Armer, 1993; Jackson et al., 2000; Johnson & Hlava, 1994; Manion & Rantz, 1995; Sullivan & Fisher, 1994. *Evidence Grade = C*). Review coping strategies that have been successful in the past in dealing with difficult situations (Armer, 1993). Review previous successful moves (Johnson & Hlava, 1994).
 - Assess needs for assistance. Functional status will determine needs for an appropriate level of care (Holmes et al., 2003; Holmes, Krout, & Wolle, 2003; Johnson & Tripp-Reimer, "Relocation among ethnic elders," 2001. *Evidence Grade = C*). This can include ability to carry out activities of daily living (ADLs) and instrumental ADLs (IADLs). A structured scale such as the Katz Index of Independence in Activities of Daily Living (ADL) (available at <http://www.hartfordign.org/publications/trythis/issue02.pdf>) can be used if desired.
 - Assess sources of current assistance and social support (Cheek & Ballantyne, "Coping with crisis," 2001, "Moving them on and in," 2001; Johnson & Tripp-Reimer, "Aging, ethnicity, & social support," 2001. *Evidence Grade = C*). Are friends and family available to provide social support? Is there a need for family counseling?
3. Plan the move. As soon as pre-relocation indicators are identified, planning for relocation should begin. Early planning along with involvement of the older adult in decision-making is key to successful relocation (Jackson et al., 2000; Mitchell, 1999; Porter & Kruzich, 1999; Stein, Linn, & Stein, 1985. *Evidence Grade = C*).

- Assess the older adult's ability and desire to be involved in decision-making about the relocation (Johnson, Schwiebert, & Rosenmann, 1994; Porter & Kruzich, 1999. *Evidence Grade = C*). Ask, "How much do you want to be involved in making this decision about relocation?" or "Who do you want to be involved in making this decision about relocation?"
- Create opportunities for the older adult to participate in making decisions and choosing the new setting. The client's perception of choice is critical in successful relocation (Armer, 1993, "An exploration of factors," 1996, "Research brief," 1996; Castle, 2001; Johnson, 1999; Johnson, Schwiebert, & Rosenmann, 1994; Johnson & Tripp-Reimer, "Relocation among ethnic elders," 2001; Krout & Pillemer, 2003; Lee, Woo, & Mackenzie, 2002; Porter, 2001; Porter & Kruzich, 1999; Rehfeldt, Steele, & Dixon, 2000; Reinardy, 1992; Reinardy & Kane, 1999; Young, 1998. *Evidence Grade = C*). When older adults relocate after hospitalization, they are often less involved in decision-making (Reinardy, 1992. *Evidence Grade = C*). Promote involvement by providing opportunities for older adults to control and manage aspects of decision-making as desired and within their capabilities.
- Communicate with the older adult using sound principles of therapeutic communication (Johnson, Schwiebert, & Rosenmann, 1994; Johnson & Tripp-Reimer, "Relocation among elders," 2001; Manion & Rantz, 1995; Mitchell, 1999; Reinardy & Kane, 1999; Sullivan & Fisher, 1994. *Evidence Grade = D*). Develop a therapeutic relationship by focusing on the older adult person and use a partnership approach. Advocate for the older adult (Johnson, Schwiebert, & Rosenmann, 1994). Ask, "What do you want and how can I help you to get it?" Interview the older person and family separately because the family can sometimes be a deterrent to clear communication with the older adult (Reinardy & Kane, 1999).
- Provide and discuss information about housing options (Armer, 1993, "An exploration of factors," 1996, "Research brief," 1996; Cheek & Ballantyne, "Coping with crisis," 2001; Johnson, 1999; Johnson, Schwiebert, & Rosenmann, 1994; Johnson & Tripp-Reimer, "Relocation among ethnic elders," 2001; Krout & Pillemer, 2003; Magilvy & Congdon, 2000. *Evidence Grade = C*).
- Refer older adult and family to appropriate resources (e. g., AARP, Area Agency on Aging, Senior Centers, Society on Aging) for additional information on relocation and estate and financial planning (Cheek & Ballantyne, "Coping with crisis," 2001; Johnson, 1999. *Evidence Grade = D*). Encourage them to obtain at least one of the following:
 - AARP. (2003). *Selling a home: Self-help guide*. Retrieved June 16, 2005 from http://www.aarp.org/families/legal_issues/legal_guides/a2004-03-25-sellinghome.html
 - Lieberman, T. (2000). *Consumer Reports' complete guide to health services for seniors*. New York, NY: Three Rivers Press.
 - Morse, S., & Robbins, D.Q. (1998). *Moving mom and dad: Why, where, how, and when to help your parents relocate, making it easier for everyone*. Petaluma, CA: Lanier Publishing International, Ltd.

- Rantz, M., Popejoy, L. L., & Zwygart-Stauffacher, M. (2001), *The new nursing homes: A 20-minute way to find great long-term care*. Minneapolis, MN: Fairview Press.
 - Young, H. M., & deTornyay, R. (2001). *Choices: Making a good move to a retirement community*. Thorofare, NJ: SLACK.
4. Individualize the plan. Focus the plan on what the client needs and wants within the realm of the realistic (Hays, 2002; Jackson et al., 2000; Johnson & Tripp-Reimer, "Relocation among ethnic elders," 2001; Krout & Pillemer, 2003; Porter & Kruzich, 1999; Reinardy, 1992; Staveley, 1997. *Evidence Grade = C*).
- Incorporate the older adult's cultural and ethnic preferences and values into the plan (Armer, 1993; Hays, 2002; Johnson & Tripp-Reimer, "Aging, ethnicity, & social support," 2001, "Relocation among ethnic elders," 2001. *Evidence Grade = D*).
 - Determine what the older adult considers to be the most important criteria for selecting the long-term care setting (Hays, 2002; Reinardy & Kane, 1999. *Evidence Grade = C*).
 - Assist the older adult in finding a residence that is a good match for the older adult's personality and needs (Alcock et al., 2002; Johnson, Schwiebert, & Rosenmann, 1994; Krout et al., 2003; Porter, 2001; Ryff & Essex, 1992; Staveley, 1997. *Evidence Grade = C*). Persons who experienced a poor fit between their needs and services available in the new residence had poorer outcomes after relocation (Ryff & Essex, 1992).
5. Promote coping while making a relocation decision. Acknowledge that relocation is stressful and use a whole-person approach as well as strengthening the older person's support system (Jackson et al., 2000; Magilvy & Congdon, 2000; Staveley, 1997. *Evidence Grade = C*).
- Help the older adult reframe the event by focusing on the positive and by emphasizing the older adult's strengths (Lee, Woo, & Mackenzie, 2002; Reinardy, 1992; Sullivan & Fisher, 1994. *Evidence Grade = C*).
 - Strengthen and improve the older adult's coping strategies (Jackson et al., 2000. *Evidence Grade = C*).
 - Provide opportunities to discuss perceived losses and gains related to the planned move (Armer, 1993. *Evidence Grade = C*).
 - Strengthen the older adult's support system by including family in the process (Armer, 1993, "An exploration of factors," 1996; Jackson et al., 2000; Johnson, Schwiebert, & Rosenmann, 1994; Johnson & Tripp-Reimer, "Aging, ethnicity, & social support," 2001, "Relocation among ethnic elders," 2001; Rossen & Knafel, 2003. *Evidence Grade = C*). Encourage continuing support from family and friends before, during, and after relocation.
 - Long-term care facilities should revise procedures for admission to decrease stress for relocating older adults and their families (Cheek & Ballantyne, "Coping with crisis," 2001. *Evidence Grade = C*).
6. Assist with pre-move preparation. Provide factual information about the chosen residence and fully inform older adult of what to expect. Older adults need to be well-prepared for the move and predictability is key in post-relocation adjustment (Armer, 1993; Krout & Wethington, 2003; Rehfeldt, Steele, & Dixon, 2000; Rossen & Knafel, 2003. *Evidence Grade = C*).
- Obtain information about the chosen residence including room dimensions, floor layout, door and window placement, dress code,

laundry facilities, religious services, how to access groceries and other needed items, and who to ask for assistance (Manion & Rantz, 1995; Rossen & Knafel, 2003; Staveley, 1997. *Evidence Grade = C*).

- Long-term care facilities should develop materials to be given to prospective residents and families that include the specific information as listed above.
- Encourage older adult (if able) and family to visit and spend time at the residence several times prior to the move to meet key people (management, staff, residents) and to attend social events (Armer, 1993, "Research brief," 1996; Cheek & Ballantyne, "Moving them on and in," 2001; Johnson, 1999; Rehfeldt, Steele, & Dixon, 2000. *Evidence Grade = C*).
- Acknowledge the importance of possessions and help the older adult plan which furniture and possessions will move with them (Armer, "Research brief," 1996; Mitchell, 1999; Young, 1998. *Evidence Grade = C*).
- Encourage the older adult and family to identify one helper to assist with sorting through possessions, making decisions about which possessions to take to the new home, get rid of, or give away, and packing. (Johnson, 1999; Johnson & Hlava, 1994; Young, 1998. *Evidence Grade = D*). The older adult should be involved in this process as much as possible and as desired.
- Advise older adult (with assistance of family or significant others) to develop a budget with anticipated costs for living in the new setting (Armer, "An exploration of factors," 1996. *Evidence Grade = C*).
- Encourage the older adult to obtain one of the following references:
 - Harris, G. (2003). *Essential moving planning kit*. Los Angeles, CA: The American Group.
 - Hetzer, L & Hulstrand, J (2004). *Moving on: A practical guide to downsizing the family home*. New York, NY: Stewart, Tabori & Chang Publishers.
- Develop a specific plan for moving day and encourage the family or significant others to be present with the older person during the move (Manion & Rantz, 1995; Young, 1998. *Evidence Grade = C*).

7. Facilitate continuity of care. Develop a good working relationship with chosen residence. Collaboration between settings is critical to post-relocation adjustment (Manion & Rantz, 1995; Mitchell, 1999. *Evidence Grade = D*).

- Develop a profile of the older adult to share with the new residence. Involve the older adult in writing it (Staveley, 1997. *Evidence Grade = D*).
- When moving to a congregate living environment or institutional long-term care, work with the staff at the new residence to develop a culturally appropriate care plan (Johnson & Tripp-Reimer, "Relocation of ethnic elders," 2001. *Evidence Grade = D*).
- Involve a trusted health care team member throughout the move. The pre-move health care team member should stay involved and supportive for one to six months after the move (Mitchell, 1999. *Evidence Grade = D*).
- When transferring from an acute care setting to institutional long-term care setting, use a transfer sheet that describes the older adult's level of function before hospitalization and at the time of discharge. Also,

give a telephone report to long-term care facility admission coordinator (Manion & Rantz, 1995. *Evidence Grade = D*).

Assessment Criteria: Post-Relocation

The following assessment criteria should be used to identify persons who are likely to benefit the most from use of this evidence-based guideline. Essential areas for assessment include: (a) demographic characteristics, (b) current health status including mental health (depression, life satisfaction, self-esteem, cognitive impairment), (c) social network and relationships, (d) sense of control, (e) perceived adjustment, and (f) perceived satisfaction with move and new home.

Assessment Tools, Instruments, and Forms: Post-Relocation

Assessment of older adults who exhibit indicators that they may need assistance in adjusting to relocation should take place in community-based, acute care, and long-term care settings. For example, community-based settings can include physicians' offices, health departments, senior centers, and congregate housing units like subsidized apartments. Acute care settings and care encompasses care provided in hospitals, in rehabilitation units following an acute illness, or during skilled nursing visits by a home health nurse. Long-term care settings include assisted living facilities, traditional nursing homes, and continuing care retirement communities.

The assessment tool, Indicators of Relocation Maladjustment Assessment Form (see appendix A.3 in the original guideline document), should be completed during the first encounter with the older adult after relocation. The assessment data should be validated and updated periodically. The frequency will depend on the older adult's situation. Immediately after relocation, the information should be updated at least weekly for the first month, then monthly for the next six months to a year. However, in some settings like physician's offices, the data should be validated during each office visit. During home health skilled nursing visits, data should be updated at least weekly. Reassessment is also indicated if there is a sudden change in the older adult's situation in life, such as the death of a spouse or caregiver, change in functional abilities, or acute occurrence or exacerbation of an illness. The Indicators of Relocation Maladjustment Flowsheet (see appendix A.4 in the original guideline document) can be used to track the changes in these indicators.

Description of the Practice: Post-Relocation

There is a period of adjustment to relocation and it can take six months or longer (Haight, Michel, & Hendrix, 1998; Hammer, 1999; Krout & Pillemer, 2003; Mitchell, 1999; Rossen & Knafel, 2003. *Evidence Grade = C*). In one study, more than half of the older adults who were interviewed did not feel at home in long-term care after residing there between two to seven years (Hammer, 1999). The following interventions should be used to facilitate adjustment in persons who exhibit indicators of potential or actual maladjustment.

1. Tailor interventions to the older adult's personal values and preferences.
Older adults are a diverse population. Interventions to promote adjustment need to be individualized (Boyce, Wethington, & Moen, 2003; Krout &

- Pillemer, 2003; Moen et al., 2003; Porter & Kruzich, 1999; Ryden et al., 1999; Sullivan & Fisher, 1994. *Evidence Grade = C*). Older adults' adjustment is difficult to predict with a universal set of factors. Therefore, interventions should recognize personal values and support autonomy (Porter & Kruzich, 1999).
- Listen to and respect views, values, and needs of the older adult to maintain the person's identity (Hammer, 1999; Iwasiw et al., 2003; Johnson & Tripp-Reimer, "Relocation among ethnic elders," 2001; Ryden et al., 1999; Stein, Linn, & Stein, 1985. *Evidence Grade = C*). This includes being sensitive to the older adult's desire for involvement in decision-making, personal preferences when discussing care preferences as well as respecting needs and values related to ethnicity (Johnson & Tripp-Reimer, "Relocation among ethnic elders," 2001). An advisory committee of ethnic older adults could be used to identify preferences such as foods and activities.
 - Identify the older adult's personal interests (Sullivan & Fisher, 1994. *Evidence Grade = D*).
 - Provide the individual with space and privacy (Eshelman, Evans, & Utamura, 2003; Hammer, 1999; Rehfeldt, Steele, & Dixon, 2000; Reinardy & Kane, 1999; Stein, Linn, & Stein, 1985. *Evidence Grade = C*).
2. Promote personal sense of control and mastery. A sense of control, competence, and autonomy through involvement in decision-making is important during and after relocation and promotes adjustment (Armer, "An exploration of factors," 1996, "Research brief," 1996; Groger, 2002; Hammer, 1999; Iwasiw et al., 2003; Mitchell, 1999; Rehfeldt, Steele, & Dixon, 2000; Wethington, 2003. *Evidence Grade = C*). Recent movers to various types of housing units (continuing care retirement communities, assisted living, subsidized apartments) had less mastery, were older, and had lower perceived health (Wethington, 2003).
- Promote control and support autonomy by offering choices such as when and where to move, a choice of a room, where to locate items in the room, a daily schedule, and in what activities to participate (Armer, "An exploration of factors," 1996, "Research brief," 1996; Iwasiw et al., 2003; Manion & Rantz, 1995; Mitchell, 1999; Porter & Kruzich, 1999; Rehfeldt, Steele, & Dixon, 2000; Reinardy & Kane, 1999; Ryden et al., 1999; Stein, Linn, & Stein, 1985; Sullivan & Fisher, 1994; Wethington, 2003. *Evidence Grade = C*). Involvement in decision-making increases control.
 - Encourage older adult to unpack personal belongings (Manion & Rantz, 1995; Young, 1998. *Evidence Grade = D*).
 - Establish achievable goals (Ryden et al., 1999. *Evidence Grade = D*) to promote success and mastery.
3. Provide social support and activities. Maintaining close ties with and feeling affection and support from family and significant others before, during, and after relocation aids adjustment (Armer, "An exploration of factors," 1996; Porter & Kruzich, 1999. *Evidence Grade = C*). Persons in assisted living were more isolated than those who lived in the community and received home health care (Tremethick, 2001. *Evidence Grade = C*). Also, sensory deficits such as vision and hearing impairments influenced social interactions (Tremethick, 2001).
- The number of roles persons occupy decreases after a move and is predicted by a number of factors including the type of residence

- (Erickson & Moen, 2003; Iwasiw et al., 2003; Moen et al., 2003. *Evidence Grade = C*). Being older and having poorer health predicts less social activity (Erickson & Moen, 2003). It is important to provide opportunities to see old friends, make new friends, volunteer, or continue meaningful roles and activity participation such as attending church.
- Encourage support from and interaction with family, friends, and new neighbors by introducing to neighbors, extending a special invitation to social gatherings, or scheduling visits (Armer, "An exploration of factors," 1996; Iwasiw et al., 2003; Jackson et al., 2000; Rossen & Knafl, 2003; Ryden et al., 1999. *Evidence Grade = C*). Maintain family contact and participation in care (Ryden et al., 1999. *Evidence Grade = D*)
 - Encourage development of relationships with others (peers and staff) especially if there are no former friends living in the new environment (Iwasiw et al., 2003; Manion & Rantz, 1995; Porter & Kruzich, 1999; Rehfeldt, Steele, & Dixon, 2000; Ryden et al., 1999; Young, 1998. *Evidence Grade = C*). Introduce to peers and others. Establish a buddy system between the new resident and person living in the new environment (Manion & Rantz, 1995).
 - Make available animal visits and visits with children if desired (Rehfeldt, Steele, & Dixon, 2000. *Evidence Grade = D*)
 - Encourage attendance and participation in activities and social interactions with others (Armer, "An exploration of factors," 1996; Rossen & Knafl, 2003; Ryden et al., 1999. *Evidence Grade = C*). Encourage meaningful and structured activities such as hobbies, crafts, games, and volunteer opportunities (Rehfeldt, Steele, & Dixon, 2000. *Evidence Grade = D*). Implement a pleasant events schedule for residents (Ryden et al., 1999).
 - Assess preferences and opportunities for being alone in addition to meeting the need for social support (Porter & Kruzich, 1999. *Evidence Grade = C*).
 - Interact one-on-one with the new resident (Manion & Rantz, 1995; Ryden et al., 1999. *Evidence Grade = D*). Staff should spend at least five minutes daily with each new resident (Manion & Rantz, 1995).
4. Promote coping with relocation. Persons experience feelings of loss after a move including loss of autonomy and privacy, loss of ability to perform ADLs, loss of home and personal belongings, and loss of family, friends, and pets (Armer, "An exploration of factors," 1996; Iwasiw et al., 2003; Jackson et al., 2000; Lee, Woo, & Mackenzie, 2002. *Evidence Grade = C*). Confidence and competence in dealing with loss influences adjustment (Armer, "An exploration of factors," 1996).
- Assist with grieving processes to smooth transitions with more intense support in first month (Armer, "An exploration of factors," 1996; Rehfeldt, Steele, & Dixon, 2000. *Evidence Grade = C*). Schedule time to talk about the move daily during first week, then every other day, and then weekly.
 - Listen and allow older adult to talk about feelings regarding the move (Manion & Rantz, 1995. *Evidence Grade = D*)
 - Assist the older adult in coping with loss and discuss usual coping strategies (Armer, "An exploration of factors," 1996; Jackson et al., 2000; Ryden et al., 1999. *Evidence Grade = C*).

- Identify the older adult's personal strengths (Ryden et al., 1999; Sullivan & Fisher, 1994. *Evidence Grade = D*).
 - Encourage rituals to say "good-bye" to the old residence and to welcome the new space. Celebrate the move. Tell stories about the former house (Johnson & Hlava, 1994. *Evidence Grade = D*).
 - Assist persons to reframe and make sense of the move to positively influence psychological well-being and life satisfaction, and reduce depression and hopelessness (Armer, "An exploration of factors," 1996; Haight, Michel, & Hendrix, 1998; Johnson, 1992, 1996; Lee, Woo, & Mackenzie, 2002; Manion & Rantz, 1995. *Evidence Grade = C*). Some persons feel a sense of relief and security because they are no longer living alone, don't need to manage their own household, and are physically safe (Groger, 2002; Hammer, 1999; Lee, Woo, & Mackenzie, 2002; Reinardy & Kane, 1999. *Evidence Grade = C*).
 - Use life review, reminiscence, and account-making strategies to promote making sense of the move (Haight, Michel, & Hendrix, 1998; Iwasiw et al., 2003; Johnson, 1992; Manion & Rantz, 1995; Ryden et al., 1999. *Evidence Grade = C*). Account-making is purposefully listening to persons talk about and make sense of the move (Johnson, 1992). Effects of these interventions may not be evident for one year (Haight, Michel, & Hendrix, 1998).
5. Orient to the new living environment. Provide information about the move and new home; a planned approach to relocation promotes adjustment (Armer, "An exploration of factors," 1996; Mitchell, 1999; Rehfeldt, Steele, & Dixon, 2000; Rossen & Knafl, 2003. *Evidence Grade = C*).
- Welcome the older adult to the new environment (Rehfeldt, Steele, & Dixon, 2000. *Evidence Grade = D*).
 - Promote communication among residents, families, and staff (Mitchell, 1999; Ryden et al., 1999. *Evidence Grade = D*). Use presence and touch (Ryden et al., 1999).
 - Introduce to staff or personnel in the new home and include all staff (Mitchell, 1999; Porter & Kruzich, 1999; Ryden et al., 1999. *Evidence Grade = D*).
 - Establish trust and a relationship with the older adult (Manion & Rantz, 1995. *Evidence Grade = D*). Staff should spend five minutes per day with new resident.
 - Orient the older adult to the new surroundings including routines and schedules (Johnson & Hlava, 1994; Rehfeldt, Steele, & Dixon, 2000; Rossen & Knafl, 2003; Stein, Linn, & Stein, 1985. *Evidence Grade = C*). Regularly reinforce orientation (Johnson & Hlava, 1994).
 - In congregate housing and institutional types of residences, provide adequate lighting and mark the room so it is easy to find (Manion & Rantz, 1995. *Evidence Grade = D*).
6. Maintain stability or continuity of care (Manion & Rantz, 1995; Mitchell, 1999; Rehfeldt, Steele, & Dixon, 2000; Ryden et al., 1999; Stein, Linn, & Stein, 1985. *Evidence Grade = D*).
- In residences where assistance is provided, develop and adhere to a plan of care (Mitchell, 1999. *Evidence Grade = D*).
 - For older persons requiring assistance in managing health problems, ensure continuity in taking medications, keeping physician appointments, and treating illness (Reinardy & Kane, 1999; Stein, Linn, & Stein, 1985. *Evidence Grade = C*).

- Move the older adult's personal objects into the new environment (Manion & Rantz, 1995; Rehfeldt, Steele & Dixon, 2000; Ryden et al., 1999; Stein, Linn, & Stein, 1985; Young, 1998. *Evidence Grade = D*).
 - Maintain continuity in the older adult's daily patterns of living (Manion & Rantz, 1995; Ryden et al., 1999; Young, 1998. *Evidence Grade = D*).
 - Provide materials to encourage activities or hobbies that are of interest to the older adult (Ryden et al., 1999. *Evidence Grade = D*).
 - Maintain contact with and involve family and friends in care of the older adult (Manion & Rantz, 1995; Porter & Kruzich, 1999; Stein, Linn, & Stein, 1985. *Evidence Grade = D*).
 - Include families and ethnic communities in the services and programs provided to residents of congregate and institutional housing to facilitate the continued involvement of older adults in the larger community (Johnson & Tripp-Reimer, "Relocation among ethnic elders," 2001; Wethington & Krout, 2003. *Evidence Grade = D*).
 - Point out consistencies in the older adult's environment such as keeping a favorite chair or afghan, photos of family, or schedule of daily activities like meals and bathing (Johnson & Hlava, 1994. *Evidence Grade = D*).
7. Ensure meeting of physical and psychosocial needs (Mitchell, 1999. *Evidence Grade = D*). Residents of "service-poor" apartments, (e.g., independent living subsidized housing) had more unmet physical and psychosocial needs, more functional limitations, and more needs for services than residents of "service-rich" residences like assisted living and continuing care retirement communities. Furthermore, those in the "service-rich" environments actually used fewer services than older persons residing in "service-poor" apartments (Holmes et al., 2003; Holmes, Krout, & Wolle, 2003. *Evidence Grade = C*).
- Support the older adult's highest level of functioning, and thus, their autonomy (Groger, 2002; Krout & Pillemer, 2003; Ryden et al., 1999. *Evidence Grade = C*).
 - Housing personnel and managers should refer older adults to support services as needed (Holmes, Krout, & Wolle, 2003. *Evidence Grade = C*).
 - Ensure that assistance with personal care is adequate (Reinardy & Kane, 1999. *Evidence Grade = C*).
 - Provide additional assistance to persons with sensory deficits such as deafness and to those who cannot walk (Porter & Kruzich, 1999. *Evidence Grade = C*).
 - Refer older adults to appropriate health care providers for treatment for depression or other medical problem management (Rehfeldt, Steele, & Dixon, 2000; Ryden et al., 1999. *Evidence Grade = D*).

Nursing Interventions

The Nursing Interventions Classification (NIC) is a comprehensive, standardized classification of interventions that nurses perform. The Classification includes the interventions that nurses do on behalf of patients, both independent and collaborative interventions, both direct and indirect care. An intervention is any treatment, based upon clinical judgment and knowledge that a nurse performs to enhance patient/client outcomes. Nursing Interventions Classification can be used in all settings (from acute care intensive care units, to home care, to hospice, to

primary care) and all specialties (from critical care to ambulatory care and long term care) (Dochterman & Bulechek, 2004).

Please refer to the original guideline document for the Nursing Interventions Classification.

Definitions:

Evidence Grading

- A. Evidence from well-designed meta-analysis
- B. Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g., assessment, intervention or treatment)
- C. Evidence from observational studies (e.g., correlational descriptive studies) or controlled trials with inconsistent results
- D. Evidence from expert opinion or multiple case reports

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Reduction of relocation stress and promotion of adjustment

Subgroups Most Likely to Benefit

- Older, unmarried men and women
- Lower socioeconomic status
- Poor health status
- Signs of depression
- Lower life satisfaction
- Low self-esteem
- Cognitive impairment
- Decreased social network, integration and participation
- Poor sense of mastery and control

- Limited coping skills
- Unfulfilled expectations and mismatch between needs, values and services

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This evidence-based practice protocol is a general guideline. Patient care continues to require individualization based on patient needs and requests.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The "Evaluation of Process and Outcomes" section and the appendices of the original document contain a complete description of implementation strategies.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Chart Documentation/Checklists/Forms
Resources
Staff Training/Competency Material

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Hertz JE, Rossetti J, Koren ME, Robertson JF. Management of relocation in cognitively intact older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2005 May. 63 p. [65 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Not available at this time.

Print copies: Available from the University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core, 4118 Westlawn,

Iowa City, IA 52242. For more information, please see the [University of Iowa Gerontological Nursing Interventions Research Center Web site](#).

AVAILABILITY OF COMPANION DOCUMENTS

The original guideline document and its appendices include a number of implementation tools, including screening tools, outcome and process indicators, staff competency material, and other forms.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on November 11, 2005. The information was verified by the guideline developer on November 21, 2005.

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