Perceptions, thoughts, and feelings of rural nursing home residents associated with relocation to a nursing home
by Bonnie Sue Daniels

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University

Abstract:
The purpose of this study was the exploration of perceptions, thoughts, and feelings of the rural elderly associated with relocation to, and life in, a nursing home. Conceptualization of the relocation process was possible through application of transition theory.

A descriptive design was used for this investigation. Participants constituted a convenience sample of 19 elderly persons. The study was conducted in four nursing homes in rural communities located in south-central Montana. A semi-structured interview guide was used to collect data during face-to-face interviews.

Important findings which emerged from the data were: relocation constituted a major life event; long distance relocation contributed to feelings of social isolation; and lack of decisional control regarding nursing home selection was a problem for most rural elders. The importance of personal possessions related to residents' self-identity emerged as a critical element in the transition process for rural elderly.

Several implications for rural nursing arose from the study. Sensitization of health care professionals to the difficulties the rural elderly experience with relocation was at the core of most implications. Recommendations for further research focusing on relocation of the rural elderly are made. Use of transition theory can provide a workable framework for improved care of all nursing home residents.

PERCEPTIONS, THOUGHTS, AND FEELINGS OF RURAL NURSING HOME RESIDENTS ASSOCIATED WITH RELOCATION TO A NURSING HOME

by

Bonnie Sue Daniels

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of the requirements for the degree

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APPROVAL

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This thesis has been read by each member of the graduate committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

April 14, 1994
Date

Ruth Vandenhoost
Chairperson, Graduate Committee

Approved for the Major Department

April 18, 1994
Date

Kathleen Chafey PhD., R.N.
Head, Major Department

Approved for the College of Graduate Studies

5/2/94
Date

Graduate Dean

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The purpose of this study was the exploration of perceptions, thoughts, and feelings of the rural elderly associated with relocation to, and life in, a nursing home. Conceptualization of the relocation process was possible through application of transition theory.

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CHAPTER 1

THE RESEARCH PROBLEM

Introduction

Despite the relatively low percentage of nursing home admissions, nursing home residency is a normative expectation of the elderly and is associated with a negative stereotype (Brooke, 1989a; Johnson, M.A., 1990; Moody, 1987; Young, 1990). Many people view nursing homes as "old folks homes" and the residents as senile, asexual, withdrawn, rigid, inflexible, dependent, and socially deprived (Biedenharn & Normoyle, 1991; Numerof, 1983; Thompson, 1989). The concept that nursing homes are "a place to die" is another negative, yet common, perception (Chenitz, 1983). Since nursing home admission usually occurs at a vulnerable time in life and frequently is associated with negative stereotypes, entering a nursing home may be the most significant relocation in the life of the aging person (Damon, 1982; Mikhail, 1992; Porter & Clinton, 1992).

Though it is recognized that relocation is stressful for all ages, the elderly often adapt negatively to relocation and the changes which accompany it (Damon, 1982;

Resnick, 1989; Seelbach & Hansen, 1980; Van Auken, 1991). Because many rural communities do not have nursing homes, elderly persons may be relocated several miles from friends and family. Separation from known social support has been shown to add to the sense of change and may influence the individual's perception of loss associated with relocation (Resnick, 1989). Most relocation studies have been conducted in an urban setting. Therefore, it is unclear that the issues facing relocated urban elderly are the same issues that face the relocated rural elderly.

Population Demographics

More than one million elderly Americans are admitted each year to approximately 18,000 nursing homes (Vladeck, 1989). Mean length of resident stay in nursing homes is calculated to be 18 months, with a median close to 100 days (Vladeck, 1989). Resident capacity of the average nursing home in the United States is fewer than 100 persons (Vladeck, 1989). In Montana, 98 nursing homes serve the state's elderly population (United States Department of Health and Human Services, 1990). Currently, 12.6% of the United States population is 65 years of age and over (Bureau of the United States Census, 1992), whereas, the elderly population in Montana is 13.3% (Bureau of United States Census, 1992).

Increased longevity has resulted in repeated admissions and relocations of the elderly into acute and long-term care facilities (Burnette, 1986). According to the Encyclopedia of Aging (Maddox, 1987), the probability of a period of short or long-term relocation after the age of 65 is near 63%. Today, 5% of the nation's elderly and 25% of those over 85 years of age experience nursing home admission (Young, 1990). Using the current ratio of one nursing home resident to every 20 persons, the number of persons in nursing homes by the year 2030 is estimated to be three million (Bowsher & Gerlach, 1990).

In rural areas the elderly make up 25% of the population (Bureau of the United States Census, 1992), yet little research has been directed toward understanding the perceptions, thoughts, and feelings of elderly residents in rural nursing homes. Attention needs to be directed toward recognition of the psychological and psychosocial problems that arise with relocations. Increased knowledge and better understanding of the phenomenon of relocation can enable health care professionals to move toward minimization of the problems associated with relocation.

Significance for Nursing

This study can serve to expand the knowledge related to understanding the perceptions, thoughts, and feelings of the rural elderly person relocated to a nursing home.

Through increased understanding of the elderly nursing home resident, the clinician can work in a greater capacity as client advocate, mediator, and caregiver. Knowledge gained in this study can assist health professionals in the creation of appropriate interventions to enhance the quality of life and well-being of the rural nursing home resident. Research results can also be useful to nursing educators as schools move to expand the areas of gerontological and rural nursing in the curriculum.

Independence, hardiness, a strong desire for privacy, and self-reliance have been identified as traits of rural residents (Buehler & Lee, 1992; Casarett, 1991; Dietz, 1991). Often, geographical isolation, together with independence, hardiness, self-reliance, and a strong desire for privacy, strengthen rural residents but may also contribute to lack of care (Lee, 1993). Rural communities have a high population percentage of elderly, lack significant community health care resources, and have lower personal income levels (Bureau of the United States Census, 1992; Johnson & Barba, 1992). Rural environments and rural elderly residents present a special mixture of challenges and dilemmas for health care providers.

Most nursing home residents receive little direct medical supervision. Physician and allied health services tend to be episodic and are provided to meet federal and state regulatory criteria (Mitty, 1988; Vladeck, 1989).

Nursing home residents with acute medical problems which cannot be managed by nursing care, a telephone consultation, or standing orders are most often transported to the offices of the primary physicians or to hospitals (Vladeck, 1989). Therefore, nursing, with its holistic orientation, is especially suited to affect health care for elderly nursing home residents.

Though many nursing home residents require only a safe, supportive environment, assistance with activities of daily living, and regular professional nursing supervision, many residents are admitted who require more intensive care. Nursing home residents are routinely admitted directly from acute care hospitals with infusion pumps, telemetry, and respiratory therapy. Proper care of the ill residents requires the expertise of registered professional nurses.

In the years since implementation of diagnostic related groups (DRGs) and resource utilization groups (RUGs) the average age of nursing home residents has risen from 75 years of age to 85 years (Mitty, 1988). Acuity ratings have also increased (Mitty, 1988). Case management for long-term care of elderly nursing home residents is provided by nursing, whether guided by the traditional wellness model or the geriatric rehabilitation model.

The importance of nursing homes arises out of the demographic phenomenon of the aging population and presents

a unique challenge for the present health care system (Vladeck, 1989). Growth of the elderly population affects not only health care professionals, but all citizens. One in every four persons in the rural population is over the age of 65 years (Bureau of United States Census, 1990). In an era of spiraling health care cost and curtailment of health care services, efforts to prevent physical, emotional, or psychosocial illnesses can serve to contain health care expenses and better utilize existing services.

From a national perspective, the issue of elderly relocation gained political prominence in 1987 (Vladeck, 1989). At this time the first significant federal legislation on standards of care was established for nursing homes (Umoren, 1992; Vladeck, 1989). Persons most likely to use nursing homes have the weakest family supports, the lowest incomes, and are the most socially isolated (Vladeck, 1989; Wells & Macdonald, 1981). Thus, elders most in need of nursing home care can least afford it. According to the Select Committee on Aging (1988), 31% of the total annual health care expenditures in the United States is spent on individuals 65 years of age and over (Wright, 1990). Medicaid, a public expenditure, provides over 40% of the cost of nursing home care in the United States (Buchanan, Madel, & Persons, 1991). Medicare and private health insurance account for less than three percent of nursing home payments (Buchanan et al., 1991).

Rural residents have some of the lowest per capita incomes in the nation and are geographically and socially isolated (Bureau of United States Census, 1990; Vladeck, 1989; Wells & Macdonald, 1981). Rural areas also have the highest percentage of elderly persons (Bureau of United States Census, 1990). Based on financial, social, and humanitarian issues, relocation of the rural elderly is an issue for all Americans.

Conceptual Framework

Aging is a time of change (de la Cruz, 1986; Horwood, 1986; Young, 1990). Changes for the elderly include the areas of lifestyle, financial status, physical health, mental acuity, and interpersonal relationships (Burnette, 1986; Damon, 1982; Mikhail, 1992). Relocation to nursing homes implies a significant change.

Much has been written during the last 20 years regarding relocation of the elderly into a nursing home (Burnette, 1986). Research studies have concluded that, for many of the elderly, relocation produces significant adverse physical and emotional responses (Carboni, 1990; Damon, 1982; Thomasma, Yeaworth, & McCabe, 1990).

Circumstances leading to relocation, the meaning attached to the changes precipitating the relocation, and the response to the relocation are unique to each individual (Young, 1990). Transition is defined as a

"passage from one position to another" (Costello, 1990, p. 1417). Transition theory establishes a framework for understanding the perceptions, thoughts, and feelings of the elderly toward relocation and nursing home life.

Transition is influenced by three important dimensions: (1) characteristics of the particular transition, (2) characteristics of the individual, and (3) characteristics of the pre- and post-transition environments (Schlossberg, 1981). Bridges' (1980) process model describes transition as having three segments or phases: (a) endings, (b) neutral zone, and (c) new beginnings. Bridges' transition model incorporates the characteristics described by Schlossberg and the aspect of time in the process of relocation.

Endings, the first phase of transition, involves closure or saying goodbye to people, places, possessions, or life styles. Change and loss are incorporated in the endings phase. Changes, and the accompanying losses, precipitate feelings of self doubt, loneliness, and isolation (de la Cruz, 1986). During relocation, emotional support is an important aspect of care (Brooke, 1989a, 1989b). Necessary time to grieve the changes and losses which occur during the endings phase is often overlooked by health care personnel in an attempt to orient a new resident to his/her surroundings (Young, 1990).

The second, or neutral phase of transition, encompasses reorientation to new environments, people, and situations. Emotional upheaval may occur in the neutral phase which can create a need for personal support and understanding. During this time in the transition process, persons frequently feel disconnected from the past as well as the present (Bridges, 1980).

New beginnings, the third phase, occurs when the individual has had time to progress through the first two phases and begins adapting to the new surroundings or situation. New beginnings is marked by increased interests in new activities and greater interest in persons, a realignment of thinking, and a renewal of energy (Bridges, 1980). Bridges' transition process model provided a framework from which to better understand the personal perceptions, thoughts, and feelings of the rural elderly nursing home resident associated with relocation to, and life in, a nursing home.

Purpose

The purpose of this study was to explore the perceptions, thoughts, and feelings of rural elderly nursing home residents associated with relocation to, and life in, a nursing home.

Definitions

Definitions used in this study included the following:

1. Relocation was globally defined as "changing one's residence" (Costello, 1990, p. 1138). For the purpose of this study the change of residence was defined as moving from home or hospital to a nursing home.

2. Elderly was defined as persons 65 years of age and older.

CHAPTER 2

LITERATURE REVIEW

Mortality and Morbidity

Documented studies regarding elderly relocation were first conducted in the 1960s (Burnette, 1986) and concentrated on intra- or inter-institutional moves. Early studies of elderly relocation were based on the belief that relocation to nursing homes was traumatic and sometimes resulted in death. Mortality and morbidity rates associated with relocation were the foci of many early relocation studies (Nirenberg, 1983; Thomasma et al., 1990; Zuckerman, Kasl, & Ostfeld, 1984). Words such as transplantation shock, stress, mortality, and transfer trauma were used routinely in conjunction with the process of relocation (Coffman, 1981).

Early studies examined the negative effects of emotional stress and the traumatic aspects associated with relocation (Aldrich & Mendkoff, 1963; Lieberman, 1961). A study of 640 individuals determined that risks associated with relocation were higher than acceptable for the majority of persons (Lieberman, 1961). Risks associated with relocation were determined to be independent of

preparation, condition of the individual, or the environment (Lieberman, 1961). Aldrich and Mendkoff (1963), in a classic, frequently reviewed study, reported a high mortality rate of aged and disabled persons who were forced to relocate due to an institutional closure. Jasnau (1967) introduced the additional variables of mass versus individual move and preparation. Results showed a decrease in mortality rates for those individuals who received preparation prior to the relocation compared to those persons moved in mass without prior preparation (Jasnau, 1967).

Mortality and morbidity rates continued to be the principal foci of relocation research in the 1970s. Additional variables such as preparation, environmental change, and choice were beginning to be added to the study of elderly relocation in the 1970s (Gutman & Herbert, 1976; Markus, Blenkner, Bloom, & Downs, 1971). Bourestom and Tars (1974) investigated the mortality rates of involuntarily relocated elderly persons from one institution to another compared to a non-relocated group. Findings showed a dramatic increase in mortality rates for the relocated group compared to the non-relocated group.

In a study of 350 chronically ill elderly relocated to a new facility, Zweig and Csank (1975) found a significant decrease in the mortality rate from the previous years of study. Decreased mortality rates were attributed to

organized preparation programs prior to relocation. Pablo (1977) reported higher than normal morbidity and mortality rates which persisted up to one year post relocation. Results of more recent studies have conflicted with Pablo's findings and have shown no change in mortality and morbidity rates of relocated chronically ill elderly (Haddad, 1981; Mirotznik & Ruskin, 1984; Nirenberg, 1983).

Research findings, as a whole, continued to be inconsistent during the 1970s. Relocation was generally accepted as a significant change in the lives of individuals. Analysis of research data indicated relocation produced significant psychological and physiological stress (Coffman, 1981). The difference in outcomes were attributed to the integrative versus disintegrative processes in the support systems of the relocated persons (Coffman, 1981).

While only 5% of the total elderly population are institutionalized at one time, it has been estimated that 25-50% of all elderly persons enter nursing homes for short, primarily rehabilitative, stays (McConnel, 1984). The high percentages of nursing home admissions presented a strong case for moving further away from frequent use of mortality and morbidity rates as dependent variables. During the 1980s, public policy focused on legislation designed to ensure high quality care for institutionalized individuals (Burnette, 1986; Vladeck, 1989).

Predictability and Control

Neugarten (1969) studied developmental changes in aging associated with perceived control of the environment. According to Neugarten (1969), elders developed an increasingly external locus of control. Elders viewed themselves as unable to overcome obstacles in their environments and unable to make changes (Neugarten, 1969).

General acceptance that relocation was a stressful experience for the elderly prompted researchers to question how best to mitigate the negative consequences of relocation. Schulz and Brenner (1977) analyzed the existing literature on relocation and proposed a theoretical model based on the variables of predictability and control. Schultz and Brenner's (1977) proposed predictability and control of both pre- and post-relocation environments were affected by how individuals perceived situations. Researchers conducted relocation studies which focused on the variables of predictability and various levels of control. Areas of control studied were: (1) locus of control, (2) perceived control, (3) personal control, and (4) decisional control (Bensink, Godbey, Marshall, & Yarandi, 1992; Bowsher, 1990; Bowsher & Gerlach, 1990; Davidson & O'Connor, 1990; Hyer, Matteson, & Siegler, 1982; Reinardy, 1992).

Health of the relocated elderly was not considered a study criterion until the late 1970s and early 1980s (Burnette, 1986; Young, 1990). Kasl (1972) performed an extensive review of the physical and mental health effects of involuntary relocation and the institutionalization of the elderly. Kasl's (1972) work concluded with suggestions for interdisciplinary studies including measurements of biochemical and health variables by laboratory and clinical examination.

Life Satisfaction

Life satisfaction, associated with involuntary relocation, was the focus of study for a number of researchers. Smith and Brand (1975) showed a decrease in life satisfaction in an involuntarily relocated group compared to a non-relocated group. Borup, Galligo, and Hefferman (1979) found involuntary relocation resulted in positive outcomes on health and functional status with no increase in mortality rates. Differences in study results between Borup et al. (1979) and Smith and Brand (1975) appeared related to willingness of subjects to relocate. Smith and Brand (1975) reported an unwillingness in their sample to relocate while Borup et al. (1979) reported a willingness on the part of the study sample to relocate. Differing study results have become a point of controversy among gerontologists (Bourestom & Pastalan, 1981; Burnette,

1986). Haddad (1981) concluded that relocation for the purpose of providing more appropriate health care does not decrease life satisfaction.

Adjustment and Adaptation

Several researchers examined the process of adjustment and adaptation to the nursing home for the relocated elderly. Pattie and Gilleard (1978) compared three groups of elderly persons with varying degrees of independence. Study results failed to show significant support of a general negative relocation effect. Wells and Macdonald (1981) studied interpersonal relationships and post-relocation adjustment of institutionalized elderly. Persons with close personal relationships were found to have a more successful adjustment to nursing home life. Brooke (1989a) identified four phases in the process of adjustment to life in a nursing home. Forty-four residents (93%) progressed through the four phases in eight months of nursing home residency (Brooke, 1989a). Social interaction and psychosocial adaptation, both before and after relocation, were foci of an investigation by Tesch, Nehrke, & Whitbourne (1989). Negative change or no change in resident morale was attributed to involuntary relocation within a single institution.

Assessment Tools

As researchers moved from strict quantitative data, such as mortality and morbidity rates, instruments were developed to assist in the assessment of personal and social adjustment. Relocation studies during the 1970s resulted in the development and use of numerous assessment tools (Damon, 1982; Mikhail, 1992). Assessment tools included: (1) Neugarten's Life Satisfaction Index, (2) Lawton's Analysis tool, and (3) Activity and Attitude Inventory of Kasteler (Kasteler, Gray, & Carruth, 1968; Lawton & Cohen, 1974; Neugarten, 1969). Inconsistent findings have been associated with the variety of instruments used and methodological difficulties encountered with their use (Burnette, 1986; Coffman, 1981; Young, 1990).

Gerontological Nursing Research

Gerontological nursing research began in the late 1970s as nurses realized they were intimately involved with assessing and caring for the elderly (Burnette, 1986). Early studies looked at the patients' sense of control, the conditions surrounding relocation, and characteristics of the person relocated (Grey, 1978; Mullen, 1977; Wolanin, 1978). Researchers related the degree of mortality to the degree of planning and preparation prior to relocation.

Grey (1978) described the experience of 137 nursing home residents who were relocated to a new facility. Residents who were psychologically prepared for the move had a lower rate of mortality (Grey, 1978).

Intra-institutional and inter-institutional relocations were the primary foci of gerontological nurse researchers during the early years of nursing research in this field. Variables examined included control, predictability, choice, and social support (Amenta, Weiner, & Amenta, 1984; Bonardi, Pencer, & Tourigny-Rivard, 1989; Brown, Cornwell, & Weist, 1981; Wolanin, 1978).

Results of the nurse generated studies in the 1970s were inconsistent - increased or decreased mortality, more or less life satisfaction, and higher or lower levels of activity (Burnette, 1986; Nirenberg, 1983). Mortality rates varied from a low of 5% to 50% higher than normal (Grey, 1978). Studies were small in scale, populations were not comparable nor randomly selected, longitudinal design was lacking, and there was no accounting for the non-equality of the environments to which the subjects were moved (Thomasma et al., 1990). In spite of the inconsistencies, early investigation of multidimensional factors expanded the knowledge base of geriatric practitioners and health care providers, stimulated discussion, and moved the discipline away from the extreme variables of sickness and death (Nirenberg, 1983).

Legal Issues

A 1980 United States Supreme Court decision served to give focus to relocation studies in the 1980s (Burnette, 1986; Cohen, 1981). Justice Blackmun rejected the argument of transfer trauma, concluding that though portions of the accumulated data pertaining to relocation trauma demonstrated negative consequences for the elderly person, results were inconsistent and therefore no finite decision could be drawn. As stated by Bourestom and Pastalan (1981), whether or not relocation had negative or positive effects was no longer the question. Perhaps the most important question was now related to the development of the most effective strategies for mitigating the negative consequences of relocation (Bourestom & Pastalan, 1981). Hence, a major portion of the studies from the 1980s focused on what could be done to temper or abate the negative effects of relocation.

Reimbursement Issues

By the 1980s, the effects of Medicare and the diagnostic-related groups (DRGs) were felt strongly by the aged population (Engle, 1985). Medicare limitations on reimbursement, as well as use of DRGs, caused elderly persons to be discharged from acute care hospitals, into communities earlier than ever before (Gale & Steffl, 1992;

Langer, Drinka, & Voeks, 1991). Without the lengthier acute care hospital stays, many elderly persons were not able to return to their private homes and were admitted to long-term care facilities (Mitty, 1988). Changes in the federal-state implemented Medicaid programs have also affected nursing homes and the elderly (Vladeck, 1989). Cost-containment strategies have been implemented in most nursing homes in an attempt to maintain operational costs within reimbursement amounts (Schneider, 1992; Soumerai, Ross-Degnan, Avorn, McLaughlin & Choodnovskiy, 1991; Vladeck, 1989). Restrictions on the number of reimbursable medications, monthly limits on optional services, and maintenance of minimal staffing levels have become commonplace as nursing homes attempt to operate within an increasingly narrow reimbursement margin (Schneider, 1992).

Clinically Focused Studies

Many studies have used a more clinical focus to determine the effects of nursing home relocation on the elderly. Nirenberg (1983) conducted a clinical study directed at mitigating the negative effects of relocation. The project endeavored to determine the physiological and psychological effects of relocation by administering a behavioral skills and cognitive skills program to relocated elderly (Nirenberg, 1983). Results indicated post relocation changes were positive for those using the

behavioral skills program but not so with residents using the cognitive skills program. Moos and Lemke (1986) recorded a modest increase in resident-visitor interaction through manipulation of the physical environment of the nursing home. Holzapfel, Schoch, Dodman, and Grant (1992) used the physiologic variables of respiration, blood pressure, and pulse to measure residents' response to relocation. Researchers determined the effects of relocation to be positive if adequate preparation accompanied the relocation (Holzapfel et al., 1992).

Brooke (1989a), in a longitudinal, participant-observer clinical study, attempted to provide answers to the question of relocation adjustment. Several nurse researchers concentrated on individual responses to relocation and the factors that affect adaptation (Amenta et al., 1984; Numerof, 1983). Chenitz (1983), using a qualitative approach, described events or circumstances affecting newly relocated persons. A longitudinal study conducted by Dimond, McCance, and King (1987) explained changes in health and mood of residents as responses to adjustment that occurs over time. Engle (1985) looked at the variables of mental status and functional health of relocated elderly. The concept of relocation as a process occurring over a period of time was well supported in the above studies.

Loss

Loss has been recognized as an element of the aging process (Burke & Walsh, 1992; McKenzie, 1980). McCracken (1987) and Wapner, Demick, and Redondo (1990) studied the impact of loss of possessions on the relocated elder. Wells and Macdonald (1981) studied the impact of inter-institutional relocation and the loss of a familiar environment on the interpersonal networks and physical and psychological adjustment. Study results indicated the loss of a secure, known environment was mediated by the presence of close interpersonal relationships. Adverse effects following moves were seen less in residents with supportive relationships. Loss and its accompanying change provided additional dimensions of study to the relocation process.

Ego Integrity and Self-Esteem

Persons living in a nursing home are known to be more susceptible to decreased self-esteem (Coleman, 1984). Ego integrity and self-esteem have been the subject of several studies involving relocated elderly persons. Pensiero and Adams (1987), in a study which focused on the effects of clothing on the relocated elderly, concluded dress was an important link to the "outside" world. Dress was also observed to add quality to life. Self-esteem was determined to be connected to clothing and directly

correlated to the residents' perception of self (Adams, 1987). Maintenance of self-esteem and self-confidence influenced the functional ability of nursing home residents, led to greater sense of independence, and assisted in the adjustment process (Pensiero & Adams, 1987).

Nursing Home Stereotypes and Attitudes

During the last decade, researchers have begun to examine the attitudes and beliefs surrounding nursing home relocation. Although only 5% of the elderly population reside in nursing homes, nursing home residency remains a normative expectation of the elderly and is associated with negative stereotypes (Biedenharn & Normoyle, 1991; Brooke, 1989a; Chenitz, 1983; Moody, 1987; Numerof, 1983). Actual prior experiences are rarely the source of anxiety surrounding nursing home residency (Biedenharn & Normoyle, 1991). Too often, the response of elderly to relocation is based on views of retirement and nursing homes developed through mixed television coverage of memorable events (Biedenharn & Normoyle, 1991; Numerof, 1983; Thompson, 1989).

Children of elderly persons needing nursing home care reported feelings of sadness, helplessness, and guilt (Hatch & Franken, 1984; Schneewind, 1990). Adult children of the elderly often fear social condemnation based on

preconceived ideas of life in the nursing home garnered through sensationalized stories offered through the media (Biedenharn & Normoyle, 1991; Hatch & Franken, 1984).

Direction of Current Research

Studies conducted thus far in the 1990s have continued to focus on a number of variables. Control, predictability, choice, social support, health, coping, and adjustment have been the most prominent areas of study (Bensink et al., 1992; Bowsher & Gerlach, 1990; Oleson & Shadick, 1993; Thomasma et al., 1990).

O'Connor (1991) conducted two quasi-experimental longitudinal studies which examined the short-term consequences of physical environment on the physical outcomes of relocated elderly persons. Results of the first study indicated social exposure was beneficial to newly admitted nursing home residents. The second archival study found social exposure to be beneficial in the short term, but detrimental over a period longer than three months.

Psychological well being and perceived control in nursing home residents has been established to have a positive relationship (Bowsher, 1990; Bowsher & Gerlach, 1990). Environmental changes, when associated with choice and control, have been found to create less stress and risk for illness for the relocated elderly (Thomasma et al.,

1990; Van Auken, 1991). Oleson and Shadick (1993) described a process by which nurses may effectively help elderly persons cope with relocation into a nursing home.

Rural Relocation Research

Colsher and Wallace (1990) conducted a longitudinal study of more than 3000 geographically defined rural elderly. They found 4.7% of the subjects were relocated to nursing homes due to unforeseen illness or frailty. It had been expected that only 2.7% would be relocated during this study. Nursing home relocation of the elderly was found to be linked to dependency on others.

Rural Population Demographics

According to the Bureau of the United States Census (1992), total elderly population in the United States has reached 12.6%. Nationally, the elderly population in many rural areas is near 25% (Bureau of the United States Census, 1992). Nursing homes in the United States number in excess of 18,000 (United State Department of Health and Human Services, 1990; Vladeck, 1989).

Montana has a total elderly population rate of 13.3% with elderly population in many of the rural communities at the national level of 25% (Bureau of the United States Census, 1992). Geographically, Montana is the fourth largest state in the Union and ranks 49th (including the

District of Columbia) in the number of persons per square mile (Bureau of the United State Census, 1992). Of Montana's 56 counties, 46 contain less than six persons per square mile (Buehler & Lee, 1992). Ninety-eight nursing homes are licensed for service in Montana (United States Department of Health and Human Services, 1990). Rapid growth of the elderly population and the number of nursing homes support the need for continued study of elderly relocation.

Traits of Rural Residents

Rural residents tend to be independent and wary of health care providers (Casarett, 1991; Dietz, 1991; Jezierski, 1988; Johnson, J., 1991; Weinert & Long, 1990). A strong desire for privacy is closely linked to independence (Dietz, 1991; J. Rothan, personal communication, October 17, 1993). Rural individuals are generally self-reliant and attempt to "make do" with available resources (Buehler & Lee, 1992; Dietz, 1991). Hardiness has been identified as a characteristic of the rural elderly (McCulloch, 1991). Often, residents of rural communities are reluctant to seek or accept help until they have exhausted their personal resources and energy (Jezierski, 1988). Combined with geographic isolation, the traits of independence, self-reliance, and hardiness serve to strengthen the aging rural population but may also

contribute to lack of care (Lee, 1993). The changing demographic profile has forced the nation to focus attention on the health care needs of the elderly. As health care professionals and politicians turn attention to the elderly, practitioners in rural areas must speak out to encourage expansion of research directed at the rural elderly.

Summary

Relocation research has moved from descriptive to intervention studies (Burnette, 1986). Research during the past three and one-half decades has revealed the process of relocation to be a dynamic, non-generic event. Recent research has begun to acknowledge the individuality of the circumstances leading up to relocation, the significance connected to the changes, successive events, and responses for each elderly person (Young, 1990). Most elderly relocation research has been conducted in urban settings, creating a paucity of research regarding the relocated rural elderly.

Increased attention has been given to the impact of adaptation and adjustment to nursing home life in general. Increased attention is needed if the transition process of the relocated rural elderly is to be understood (O'Connor, 1991; Porter & Clinton, 1992; Wapner et al., 1990).

CHAPTER 3

METHODOLOGY

Design and Method

Descriptive design, using a qualitative method, was used for this investigation (LoBiondo-Wood & Haber, 1986). Semi-structured interviews were used to collect the data. Content analysis of transcribed interviews was used to discover major themes which emerged from the data. Selection of this design was based on the desire of the researcher to examine the perceptions, thoughts, and feelings of rural elderly persons relocated to nursing homes in rural communities.

Sample

Participants in the study constituted a convenience sample of elderly nursing home residents in four rural communities in south-central Montana. Access to study participants was obtained with the assistance of the directors of nursing of the selected nursing homes.

Inclusion criteria for sample participants included subjects 65 years of age or older who resided in the nursing home for one year or less. Additional inclusion

criteria were the ability to hear, understand, and speak English, and the ability to understand the purpose of the study and the interview questions.

Study participants with a medical diagnosis of dementia were excluded from the sample. Gender or chronic illness were not sources of exclusion.

The interviewer obtained a sample of 19 study participants. The actual sample size took into consideration the number of residents, admission rates of small rural nursing homes, inclusion/exclusion criteria, refusal to participate, and attrition.

The Interview

The following demographic data were collected: age, gender, race, marital status, size of the community, and size of the nursing home. Also included were support system(s), level of care, prior residence, length of stay, mobility, and sensory status (Appendix A).

A schedule of semi-structured interview questions was used to collect data (Appendix B). Interview questions focused on the three phases of transition. The first phase, endings, focused on events that led to relocation; the neutral zone covered expectations prior to coming to the nursing home; new beginnings, the third phase, was concerned with life in a nursing home. Questions developed were based on results of other studies of non-rural nursing

home residents. The researcher's previously obtained ethnographic data also influenced formation of the interview questions.

Length of time for completion of interviews ranged between 40 minutes and 1 hour and 30 minutes. The researcher was aware that the study participants might experience physical fatigue and was prepared to arrange a second interview time, if necessary. All interviews were completed in one interview session. Interviews were conducted in a private area, out of the hearing of other persons.

Pilot Test

A pilot test was conducted to help determine the clarity of the semi-structured interview questions and the ease of audio taping interviews (LoBiondo-Wood & Haber, 1986). The pilot test was conducted at a different nursing home from those selected for the study. Interview questions were presented to selected nursing home residents similar to the population of interest (Woods & Catanzaro, 1988). This was done in an attempt to evaluate the clarity of the interview questions for the population. No changes in the questions or interview format were found necessary. The investigator attempted to increase validity, which relies on the truthfulness of the respondent, by assuring

complete confidentiality of all responses and performing the interviews in a private area (Woods & Catanzaro, 1988).

Protection of Human Subjects

Purpose and Procedure

Protection of human subjects is of extreme importance in ethical research and must include informed consent of the study participants (Woods & Catanzaro, 1988). All potential study participants received an introduction to the investigator, including qualifications of the investigator and university affiliation.

The purpose of the study--exploration of the perceptions, thoughts, and feelings of rural elderly nursing home residents associated with relocation to, and life in, a nursing home--was explained to potential study participants in a letter (Appendix E) and by the researcher. In addition, the nature, duration, risks, benefits of participation, the voluntary nature of participation, and the confidentiality of participation was shared (Appendices E and F).

Lists of nursing home residents who met the inclusion criteria were accessed through the assistance of the director of nursing at each nursing home. Each study participant was asked by the researcher for permission to audiotape record the interview. One study participant

refused audiotape recording. During this interview field notes were taken.

Benefits and Risks

No benefits to study participants were promised. However, potential benefits of study participation, related to acknowledgement of previously neglected feelings and reinforcement of positive emotions, could have been experienced. Often, acknowledgement of feelings acts as a source of ventilation and relief. Ventilation can help lessen the negative effects associated with non-verbalized thoughts, feelings, and emotions. Through participation in the study, individuals had an opportunity to identify perceptions, thoughts, and feelings associated with their relocation. If study participants wanted or needed to further discuss the relocation transition, the nursing home staff was prepared to provide emotional support and access the assistance of friends, clergy, significant others, and/or the primary physician. Participants may have experienced satisfaction in contributing to the body of nursing knowledge surrounding nursing home life for the elderly and, in particular, those living in a rural state. Knowledge that the results of the study could assist clinicians who care for elderly persons in acute care facilities, nursing homes, and in communities could have provided altruistic satisfaction for study participants.

Potential risks associated with participation in the study were minimal. One risk was related to emotions that may have been triggered by questions contained in the interview. Buried feelings may have been brought to the surface by the topics covered within the interview. Frequently, talking serves not only as a means of ventilation, but also as a source of resolution as the negative emotions are aired. The investigator endeavored to serve as an interested listener for the study participants who wanted to discuss their nursing home experience. Staff nurses were informed of the potential risks to the study participants, asked to be observant of any emotional or behavioral changes or difficulties, and to intervene appropriately.

A second risk was that of study participant fatigue. Due to the nature of the interviews, age of the study participants, and possible physical conditions, study participants could have experienced fatigue. The investigator was sensitive to signs of fatigue in the study participants and was ready to terminate the interviews, if necessary. It was not necessary to terminate any interviews and no study participants requested termination of the interview.

Participation and Confidentiality

Participation in the study was entirely voluntary. No penalties of any kind resulted from refusal to participate or withdrawal from the study.

Confidentiality of study participants was ensured. Data were collected only by the researcher and kept in a locked file cabinet. Following completion of the research, the raw data were stored in a locked College of Nursing file. Duration of storage is to be five years. Names were not attached to the collected data. Interview records were coded with randomly chosen numbers. Demographic information and other study participant information was not used for identification of specific individuals. Results of the study were reported as grouped data. Interview information was not shared with the nursing home staff. A copy of the research report abstract was sent to the participating nursing homes. The finished research report was available for interested persons.

Information regarding the confidentiality procedure was relayed to each potential study participant verbally. An introductory letter (Appendix E) and a consent form (Appendix F) were left with each study participant. The consent form explained the purpose and procedure of the study.

Cost and Reimbursement

There were no financial costs to the participants. Participants were not paid for participation in the study.

Informed Consent

A verbal explanation of the study, its purpose, the procedure to be followed, and risks and benefits associated with study participation was given to potential study participants during the initial contact. A letter containing the above information and the contact phone number of the investigator was given to each potential participant (Appendix E). A description of the study, length of the interview, and the participants' freedom to terminate participation at any time was included in the proposal presentation. Informed consent was obtained from each participant and recorded by the investigator (Appendix F). Five study participants preferred not to sign the consent form. Verbal consent was obtained from the five study participants who chose not to sign a consent form. Refusal to sign was noted on the consent form of these five study participants.

Montana State University College of Nursing's Human Subject Review Committee reviewed the study relative to the maintenance of ethical research standards and protection of study participants (LoBiondo-Wood & Haber, 1986; Montana State University, 1992). Approval of the study was

obtained from the College's Human Subject Review Committee before the proposal was presented to the administrators and/or the directors of nursing of the rural nursing homes and, eventually to potential study participants.

Procedure

After obtaining approval of the research proposal from the College of Nursing's Human Subjects' Review Committee, entry into the nursing home settings was obtained through the administrators and/or directors of nursing. A letter was sent to the administrators/directors of nursing of the selected nursing homes informing them of the details of the study and asking for permission to access the residents (Appendix C). Administrators/directors of nursing were requested to sign a consent form verifying knowledge of the study and granting permission for the investigator to conduct the study at the nursing homes (Appendix D). When permission to access the potential study participants was obtained, a brief, introductory interview was conducted with the director of nursing in each nursing home. During the interview session the researcher was familiarized with the nursing home schedule and the physical layout of the facility. A list of potential study participants was formulated during the interview. All residents meeting the inclusion criteria were considered potential study participants.

Following personal introduction of the investigator to the potential study participant, a verbal explanation of the study and the participant's rights was given. An introductory letter (Appendix E) was given to each participant. The introductory letter included a phone number through which the study participants could contact the investigator for clarification of possible questions about the study. Staff nurses had access to the phone number of the researcher and were encouraged to call if the study participants requested them to do so. Telephone contact numbers of the researcher and the thesis chairperson were on the consent form given to each study participant (Appendix F). No telephone calls from study participants or nursing home staff members were received by the researcher or the thesis chairperson. The consent form (Appendix F), explaining the study and the participant's rights, was read to potential study participants and a written and/or verbal consent obtained. A waiver of signed consent was sought based on the belief that elderly persons are frequently uncomfortable with written legal documents. Following verbal agreement to participate, the interview was conducted at a time convenient for the study participant.

Each participant was asked for permission to audiotape record the interview. Refusal for audiotape recording did not exclude the study participants. Written notes were

taken during the interview and fully recorded afterwards for the one study participant who was not comfortable with the audiotape recording procedure. Interview questions were read to all study participants.

Analysis

Descriptive statistics were used to describe the study samples. The range and frequency distribution of ages within the sample groups were determined.

Interview data were analyzed through content analysis (Woods & Catanzaro, 1988). Three broad themes for data collection existed - events leading to relocation, prior expectations of nursing home life, and realities of nursing home life. Data were coded within these themes using study participants words or phrases. Inductive coding of data occurred as each interview was completed. Recurrent categories in the collected data were used to establish codes within the three broad themes.

CHAPTER 4

FINDINGS

Only 5% of individuals over 65 years of age and 25% of those 85 years of age and older live in nursing homes, yet admission to a nursing home remains the normative expectation and a negative stereotype associated with aging (Hendricks & Hendricks, 1986). Therefore, not only must the relocated individual cope with the actual changes which have taken place, but also with the symbolic implications associated with nursing home relocation (Young, 1990).

This study focused on the perceptions, thoughts, and feelings of residents in rural nursing homes in relation to their transition to nursing home life. Bridges' (1980) transition theory provided a helpful framework from which to consider relocation of the rural elderly to nursing homes.

Nursing home relocation of the elderly individual may be precipitated by physical, situational, or developmental changes. Further demands, initiated by the changes, influence the relocation transition and adjustment to nursing home life.

Each stage of transition may be marked by acceptance of the nursing facility as home and establishment of new

relationships and ties within the nursing home population. Questions in the semi-structured interview guide focused on the three major, identified phases of transition described by endings, the neutral zone, and new beginnings.

Setting

Selected residents of four rural nursing homes located in south-central Montana constituted the convenience sample for the study. Three nursing homes were comparable in size, with a resident capacity ranging from 33 to 37 beds. The fourth nursing home had a resident capacity of 78. All facilities reported occupancy rates between 98 and 100%. The nursing homes were located in towns with populations between 1000 and 2900 (Bureau of the United States Census, 1992). Population of the four counties in which the nursing homes were located varied between 2200 and 11,000 (Bureau of the United States Census, 1992).

Sample

Nineteen study participants were selected based on established criteria. Mean age of the study participants was 85.53 years, the median age was 86.92, and the mode was 74.17. Standard deviation was 7.06 years. All study participants were white. Eleven (58%) of the 19 study participants were female and eight (42%) were male.

Nine (47%) of the 19 study participants were physically independent and received minimal care; one study participant required complete, skilled care. The remaining nine (47%) study participants received intermediate care. Five (26%) study participants were able to ambulate independently, the remaining 14 (74%) of the 19 study participants required walkers or wheelchairs for ambulation. Only five (26%) of the 19 study participants used hearing aids.

Four (21%) of the 19 study participants were never married, single persons. Twelve (63%) study participants were widowed. Three (16%) of the 19 study participants were currently married.

Three (16%) of the 19 study participants lived in other states prior to their nursing home admission. The three study participants had relocated to a nursing home in Montana at the urging of their adult children who lived in Montana. The 16 study participants who lived in Montana had lived in communities with populations ranging from 260 to 5600 (Bureau of the United States Census, 1992).

Study participants had resided in the nursing homes between one and one half months to 11 months, with an average stay of 5.8 months. The median length of stay was 6.0 months, and the mode was 3.5 months. Standard deviation was 2.8 months.

Data Collection

Data were collected over a three-week period in January and February, 1994. Permission to enter the nursing homes and access potential study participants was obtained from the administrator and/or director of nursing of each nursing home. A list of residents who met the inclusion criteria was compiled by the director of nursing and/or the charge nurse on duty. The researcher obtained informed consent from all study participants. Five (26%) of the 19 study participants chose not to sign the informed consent but gave verbal consent. Study participants who refused to give written consent made statements such as, "No, I don't want to sign anything" and "I don't need to sign a paper." Audiotape recording of the interview was readily accepted by all but one study participant.

Due to limited space in the nursing homes, private interviews were conducted in the study participant's room. Each study participant was interviewed one time. Interview sessions ranged between 40 minutes to one and one half hours.

A semi-structured interview guide allowed the researcher to gather data related to three identified phases of transition. The interviews opened with questions related to the endings phase. Questions that pertained to the neutral zone of transition followed the endings phase.

The interview concluded with questions related to the third phase, new beginnings. Responses of the study participants ranged from one word to several sentences.

Endings

Three categories emerged which described the transition phase of endings. Emergent categories in the transition phase of endings were change, decision, and choice.

Change

All study participants had experienced a significant change in their physical capabilities and condition prior to nursing home admission. Study participants were asked to tell what event(s) had prompted relocation. Progressive chronic illness precipitated relocation or a change in living arrangements for ten (53%) of the study participants. Two explanations given by study participants included, "My daughter got me here . . . I was having trouble with breathing" and "'Arthur' . . . arthritis and I was keeping my wife up at night, it was hard on her."

"Old age" and "sickness" were given as precipitating events by four (21%) of the 19 study participants - "I just couldn't trust my legs anymore." The four study participants who gave "old age" as a precipitating event were in the frail elderly age category; one was 89 and

three were 90 years old. Accidents, surgical procedures for fractured extremities, and rehabilitative physical therapy precipitated nursing home admission for five of the 19 study participants.

Memories and Feelings about Change. When asked to remember feelings they had when nursing home relocation was first proposed, four (21%) of the 19 study participants stated they had planned and directed their nursing home relocation. Two study participants who had planned their nursing home relocation stated, "I had to move on" and "I wanted to go. I thought 'Oh, God' it's going to be good, it's a nice place."

One of the study participants explained her decision in this manner, "I had known for a long time that eventually I would have to [come to a nursing home] and what I was hoping was that, since I was getting close to 90, was that I had lived long enough. I've had a very good life, a good marriage, and a good kid, and grandchild and so on and I just--there just wasn't any reason to keep on living when I wouldn't be self-reliant. It wasn't that I was unhappy living, but then, there is just no logic living when you are hopeless and dependent on other people and so on."

The fourth study participant, who had planned her relocation, stated she did not remember anyone proposing

nursing home relocation. "I think it was more or less my own decision . . . I have no family here. At that point [of my depression] I think I was ready for somebody to take over. It was not until afterwards, after I was in here [the nursing home] for a while, that I suddenly realized that this is it, there was no (sigh) . . . no reversal because all my furniture and that sort of thing was either given away or sold, so . . . "

Eight (42%) of the 19 study participants stated, "I can't remember" or "don't remember" when asked to describe the feelings experienced the first day nursing home relocation was proposed. One study participant explained her inability to remember her feelings by stating, "It [the process] moved too fast."

Four (21%) of the 19 study participants had positive or neutral memories and feelings about change associated with relocation. Study participants said: "I knew I couldn't stay alone" and "I felt pretty good about it, I knew I couldn't walk." One study participant explained, "I didn't have enough strength to lift myself, [I] just reached the stage where I couldn't trust myself." Positive feelings about change associated with relocation were shared by two of the four study participants. "I wanted to go" and "I was ready to move" described their memories and feelings about the change associated with relocation.

Three (16%) of the 19 study participants stated they had negative memories about the first day nursing home relocation was proposed. The three study participants described the memories with words such as, "It was crucifixion because you didn't know whether you would be accommodating in their regime or their regime would be accommodating to your need," "I was kind of upset about it, pretty sad," and "nervous."

Views of Self with Change. Ten (53%) of the 19 study participants viewed themselves as ill or dependent at the time potential nursing home relocation was discussed. Two of the 19 study participants described themselves accepting the change, "I knew it would be difficult to live alone" and "I took it in stride."

Four of the 19 study participants did not view themselves as needing nursing home relocation and expressed surprise and uncertainty about the necessity of the proposed relocation. These four study participants stated, "I thought I always would be at home," "Alone, I wondered why [nursing home relocation was needed]," "I thought I would be going home [from the hospital]" and "I didn't feel sick." Only one study participant described herself as "ready [to relocate]."

"Manipulated" and "restricted" were used by two of the 19 study participants to describe themselves at the time of

relocation. As stated by one study participant, "I didn't view death, but I viewed a restricted lifestyle [in the nursing home], very restricted."

Decision

Decision to Relocate. All of the 19 study participants had been living independently prior to nursing home admission; therefore, the decision to relocate presented a significant change in life style. Two of the study participants had been living with their spouses. One study participant had moved into his daughter's home five months prior to relocation to the nursing home. Eleven (58%) of the 19 study participants retained possession of their homes after nursing home admission, and two study participants gave their homes to their adult children.

Of the 19 study participants, ten (53%) expressed a great desire to return home. Statements included, "It's [her home] waiting for me," "I'd like to go back," "I'm hoping to go home in the spring," and "I plan to go back home." With an element of emotion one study participant stated, "I am dying to go home, just dying to go home."

Feelings about the Decision to Sell Homes and Relocate to a Nursing Home. Six (32%) of the 19 study participants had sold their homes and had sold or distributed the contents among children and friends. When asked to

describe feelings associated with the decision to relocate and dispersal of their homes one resident said, "I didn't like it. I didn't know if I would have [legal] control of it [my home] or not."

A study participant who had relocated from another state described how he made the decision to sell his home. "I had a home in [another state] . . . I sold it. . . . at first I thought it was all right, but then again I don't know. My son-in-law, see, he come, he come to [my home state] and he got me to go with him out here with him, so I said all right I'll do that . . . so I come out here with him."

A study participant who had not sold her home was anxious to return to her home. She explained why she wanted to return home: "Prior to the accident I was taking care of myself in this big house [nine rooms located on 100 acres]. I did my own cooking, I took my own baths, and I ate what I wanted--which was fortunate (laughing). I'm all on one floor, my bath and my bedroom are adjoining, and my kitchen is around the corner, and I have a great big 28 foot living room, with all antiques, with a great big fireplace. That's why I want to go home."

Long Distance Relocation and Decision. With the encouragement of their children, long distance relocation to a nursing home was made by three study participants.

Moves were made to Montana from small towns in three other states. The three study participants who had made long distance relocation knew no one in Montana other than their family members. One of the study participants said, "I have a brother that's in a nursing home in [another state] . . . the only thing is that I would like to go see my brother, but I don't think I'm going to make it."

One study participant who had made a long distance relocation related an abrupt change in her lifestyle, "I don't have no home to go to. Before moving to the nursing home I was very active with the Senior Citizens and stuff --going shopping, taking off on trips, . . . very active. It's [the nursing home] boring, there's not much to do . . . I've resigned myself to it. I don't know anything about Montana. I didn't know a soul [in the nursing home]. Jim [her son] is going to set up my bedroom at his place so it will feel like home for me when I go over [to his home 25 miles away]."

Each of the study participants who had made long distance relocations were viewed by the researcher as socially isolated within the nursing home. One study participant stated he knew only his "partner [roommate]." The second study participant rarely left her private room, and the third study participant said she could "talk to only two ladies in here [nursing home]."

Residence and Decision. Sixteen of the 19 study participants had lived in small towns in rural Montana prior to relocation to a nursing home. Fifteen of the 16 Montana resident study participants had lived in communities with populations that ranged from 260 to 2900. One of the 16 Montana resident study participants had lived near a town of 5680 (Bureau of the United States Census, 1992). The remaining three study participants had been living out of state prior to relocation to Montana.

Eighteen of the 19 study participants first looked at their county or their family's county of residence for nursing home relocation. Study participants stated they wanted to be as close to their families as possible. One study participant stated he had first looked at a nursing home in a neighboring county because he had heard it "was a good one." He reported he had found it to be "a family affair and much cheaper." The nursing home was, he explained, unfortunately, located 100 miles from his wife and their home. He made his choice of a nursing home based on convenience for his wife and himself. "Our home is here and she has to live here [the town] . . . under the circumstances I have to stay here."

Choice

Seven (37%) of the 19 study participants made the nursing home choice for themselves. Adult children

assisted two (11%) of the 19 study participants with the choice of a nursing home. One study participant, who had made the decision to relocate and chose the nursing home without family assistance, explained, "None of my children liked it at first, but they've all pretty much come around to it." "Others" made the choice for ten (53%) study participants. "Others" were defined as the physician (2), physician and family or friend (2), and family (6). Inspection visits to nursing homes prior to relocation were made by only one study participant and by the son of another study participant.

None of the study participants experienced a waiting period after making the decision to relocate and choosing the nursing home. Due to a waiting list at the nursing home in their home towns, two (11%) of the 19 study participants found it necessary to relocate approximately 35 miles from family and friends. Lack of a nursing home in the town of residence required two additional study participants to relocate approximately 45 miles from their homes.

Opinion of Others and Choice. Seventeen (90%) of the 19 study participants stated they did not worry "one bit" about what others thought of them and their move to a nursing home. Many of the study participants stated it was

"no one's business." One study participant asked, "Why should they think unfavorably?"

Two study participants stated they had worried about what others thought of them at the time of relocation. One of the two study participants expressed her concern this way: "For a short time I did [worry]; for some reason I felt ashamed." The second study participant said he was "worried because we are not a crazy family."

Neutral Zone

During the transition phase neutral zone, nursing home residents may experience introspection and expectations. Energy is frequently focused on adjustment and the process of "settling in." Influence and adjustment were identified as categories in the second phase of neutral zone.

Influence

Study participants' responses to nursing home life were influenced by a number of experiences prior to their nursing home relocation. Influential experiences included past relationships with residents in nursing homes and prior acquaintances with current nursing home residents. Other factors reported by study participants as influential were prior acquaintance with nursing home staff members, expectations of nursing home staff behavior and treatment of residents, and the geographical closeness of family.

Early work experience in a nursing home served as an influence for one study participant.

Prior Exposure to Nursing Homes and Influence. Fourteen (74%) study participants had known persons in nursing homes prior to their own nursing home relocation. Eleven (79%) of the 14 study participants, who had known nursing home residents prior to moving into a nursing home, believed this was a positive influence on their thoughts and feelings regarding nursing home life. Comments included, "I knew they would take care of me," "I'd be taken care of," and "They treated my brother okay."

One of the study participants, who had relocated from out of state, had worked as a patient care aide in a nursing home in her younger years. This study participant felt the work experience had influenced her view of nursing homes. When asked how her experience had influenced her, she stated, "Oh, that's hard work. You bet. We didn't have the equipment like they've got now. You're on your feet all day, running, running, running." This study participant wanted to return to the nursing home she had worked in because, "I know all the girls who work there."

Prior Acquaintance with Current Nursing Home Residents and Influence. Twelve (63%) of the 19 study participants knew current nursing home residents from prior social exposure. Unanimously, the study participants reported

this "didn't bother me." One study participant expressed "strong sympathy" for those residents she knew who were Alzheimer victims. Another study participant stated, "It feels better than being with complete strangers."

New Acquaintances and Influence. Since nursing home relocation, 15 (79%) study participants had developed new acquaintances. One study participant answered, "There are only two ladies I can talk to - if you know what I mean." Another study participant explained that she had to make new acquaintances because, "They make you live with someone else," while another study participant stated, "I never pass by anyone. I know all the residents." Two (11%) of the 19 study participants reported they "never get out [of the room]" and had made no new acquaintances. Two study participants stated they knew only their "partner" [roommate] and "some [other residents]."

Prior Acquaintance with Staff and Influence. Only five (26%) of the 19 study participants knew any of the nursing home staff prior to relocation. Prior acquaintance with nursing home staff members was seen as "okay - good" by one study participant. Another study participant lamented, "Sometimes it's almost too good when they all think they know [me]." As a long-time, prominent citizen in the community prior to her nursing home relocation, the study participant was known by most of the nursing home

staff. "They think they know [me]" reflected the study participant's sense of frustration surrounding violation of personal privacy. Frustration occurred for the study participant when she felt the nursing home staff acted as if they knew her feelings or desires. Three study participants reported no feelings related to his/her prior acquaintance with nursing home staff.

Prior Expectations of Treatment by Nursing Home Staff and Influence. Seventeen (89%) of the 19 study participants stated that, prior to relocation, they had no expectations of the nursing home staff related to treatment of residents. "I expected them to treat me as well as I treated them" was an expectation of one study participant. A second study participant with prior expectations of the nursing home staff answered, "Good [treatment of residents], . . . They're [staff] almost too good."

Closeness of Family and Friends and Influence. Closeness of family and/or friends played a significant influence in nursing home selection for 15 (79%) of the 19 study participants. Responses regarding the influence of family and/or friends on selection of nursing homes included, "This is my home," "My wife, friends, and home are here," "I needed someone to depend on," and "Naturally [family was an influence]."

Nursing home availability also influenced selection. Of the seven counties represented by the 16 Montana residents within the 19 study participants, only two counties offered more than one nursing home. Two (11%) of the 19 study participants were not able to enter nursing homes in his/her town of residence because of waiting lists at the local nursing home. Of these two study participants, one knew several persons in the nursing home he entered; the second study participant knew no one in the nursing home. Relocation to nursing homes outside of his/her hometown was necessary for two study participants because there were no nursing homes in the towns of residence.

All study participants reported family and/or friends lived "near" the nursing home. "Near" was defined as "in town" and "in [home town], that's about 85 miles." Four study participants, three who had relocated from out of state and one from Montana, reported no friends (apart from family) in the local community.

One study participant felt life would be different in a different nursing home if she were closer to family. "I would feel at home there [the local nursing home which had no vacancy] because the whole family could be running in and out any old time, where here it is a matter of driving 40 miles each way so that's almost a 100 miles to come to see me."

Relocated from a nearby state, a second study participant felt she would have a different life in her home state nursing home because, "I know all the girls who work in the [nursing home]." The family of this study participant lived 25 miles from the nursing home. This study participant stated she expected nursing home life to be "confining . . . and I didn't want of be cared for. It is [confining] but, maybe when the weather breaks . . . "

Adjustment

Becoming adjusted to the new environment is a task to be accomplished during the neutral phase of transition. "Settled in" was used to describe or explain the process of adjustment.

"Settled In"--Adjusted. Becoming adjusted, or "settled in," was accomplished in the neutral zone by 15 (79%) of the 19 study participants. Four (21%) of the 19 study participants reported they did not feel "settled in" or did not know if they felt adjusted to life in a nursing home. It is interesting to note that two of the study participants who did not feel "settled in" or adjusted had two of the longest lengths of stay, ten months and nine and one half months. The remaining two study participants, who did not feel or did not know if they felt "settled in," had been in the nursing home for five months and one and one half months.

Feelings, Length of Time, and Adjustment. Reported adjustment time ("settling in" time) for 15 of the 19 study participants ranged between "about a week" to two months. "Have to [feel settled in]" were the words used by three study participants to describe their feelings associated with "settling in." Another study participant who had released her rented apartment and dispersed her belongings among family and friends, expressed her feelings, "It's depressing to know that this [indicating her nursing home room] is it."

The question related to adjustment often generated increased verbalization, especially with study participants who wanted to explain that, though they felt "settled in," their homes awaited them elsewhere. Nine (47%) of the "settled in" study participants had retained their homes and planned to return to them. One study participant explained, "You see that is my home, on the corner [pointing out the window to a home on the corner of a nearby street], I could crawl there." A male study participant stated he felt "settled in" though "It is time to go home now, the community [home town] is my home."

Suggestions to Aid in Adjustment. Few study participants had suggestions to aid in the process of adjustment or "settling in." A 98-year-old male study participant commented that to become "settled in," "You