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UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Science
DOCTOR OF PHILOSOPHY IN NURSING

TRANSITIONS TO ASSISTED LIVING WITHIN A CONTINUING CARE
RETIREMENT COMMUNITY

by

Judith H. Scott

A dissertation presented to the
FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the
requirements for the degree
DOCTOR OF PHILOSOPHY IN NURSING

May 2016

Dissertation Committee

Ann Mayo, RN, DNSc, FAAN, Chairperson

Patricia Roth, EdD, RN

Jane Georges, PhD, RN

UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Science
DOCTOR OF PHILOSOPHY IN NURSING

CANDIDATE'S NAME: Judith H. Scott

TITLE OF DISSERTATION: Transitions to Assisted Living Within a
Continuing Care Retirement Community

DISSERTATION COMMITTEE:

Chairperson

Committee Member

Committee Member

Abstract

Purpose/Aims: The purpose of this study was to explore the lived experience of older single women who moved from their independent homes to the assisted living setting, both situated within a Continuing Care Retirement Community (CCRC).

Rationale: Anecdotally, CCRC transitions have been viewed as either one dreaded possible step toward the end of life or a supportive place to open a new chapter in older adults' lives. However, no studies have actually examined this experience among older single women, who comprise a large proportion of people making this transition.

Background: Older adults move to assisted living within a CCRC when the independent home becomes too much for them to manage or their physical or psychological needs require support. The transition is common but challenging for older women, many of whom are recently widowed and facing increasing frailty. They must plan and execute the move with the help of the facility and family members, if available.

Methods: This study employed a hermeneutical phenomenological research approach to explore the lived experience of 17 older women who moved from their independent homes to assisted living within two CCRCs. Themes developed from individual participant interviews were analyzed using Van Manen's research approach to data analysis.

Findings: Three major themes surfaced from the interviews: *preplanning*, *executing*, and *adjusting* to the transition. Older women had foreknowledge of the on-campus assisted living and had their names on the waiting list. Even with facility familiarity and family and staff assistance, the move was challenging, and adjustment was difficult when participants had physical or sensory impairments.

Implications: Opportunities exist for nurses in assisted living to incorporate supportive strategies into the plans of care for residents during the transition time between independent living and assisted living. However, further research is needed to specifically investigate the factors promoting satisfying transitions in order to develop strategies to improve adjustment. Findings may also provide information for health care policy makers, assisted living administrators, and those seeking to improve the health of the rapidly aging population.

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Dedication

To my young- at- heart mother, Barbara, who inspired this dissertation study with her enthusiasm for life in a Continuing Care Retirement Community, a place she calls home. Your determination to support your friends and neighbors while you grow old together is encouraging for those of us aging right behind you. You have been my greatest cheerleader!

To my sister, lifelong friend and chaplain, who faithfully brings the Word to older adults who need hope, light, and truth in their final years on this side of Heaven.

To my husband, Jim, who cheerfully supported this doctoral journey with his unwavering love, humor and great cooking. You are a man rooted in the wisdom of God, and I am grateful for the gift of being your partner in this life.

To my adult children, who have sacrificed family vacation time while their mother studied. I believe in each of you, and encourage you to reach for your goals and dreams, while serving each other with love and respect. There is no way that I can express how much I love each of you.

To my classmates at USD and my colleagues at PLNU, for enriching my life with your wisdom, your advice, and your friendship. And to Linda Hansen-Kyle, for recognizing and encouraging my potential, and helping me not take myself too seriously.

My appreciation is extended to each of you for blessing me with such rich relationships. Without your love and support, I could not have undertaken this doctoral journey. I am deeply grateful.

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Chapter One

Introduction

Judith Scott, PhD(c), RN

University of San Diego

Introduction

Currently, Americans older than 65 years of age account for 13% of the population. This percentage is expected to more than double in the next 10 years, burgeoned by the Baby Boomer generation, the largest generation in history (Lin & Brown, 2012). By 2030 there will be an estimated 72 million in this category, more than twice as many people than in 2000. The prevalence of Alzheimer's disease is expected to double by 2050, and more than 50% of those persons will be women (US Department of Health and Human Services, 2011), adding another layer of concern for planned communities.

The story of aging belongs primarily to older women, who were the focus of the study. They are both survivors and caregivers, often with health challenges of their own. Like their mothers before them, women will continue to outlive men. Women who are now middle aged can expect to take care of children and perhaps parents for many more years, facing greater challenges to health and socioeconomic status than ever before (Lin & Brown, 2012; Turiel, 2005).

Support for older adults' ability to age in place where they presently live is a national goal as well as a philosophy (US Department of Health and Human Services, 2011). Aging in place does not preclude moving into supportive retirement communities such as Continuing Care Retirement Communities (CCRCs). This move to a higher level of care is consistent with aging in place when care designs support control, choice, and supportive relationships and reduce the functional barriers that created the need to move (Ferrand, Martinent & Durmaz, 2014; Street & Burge, 2012).

While there are different types of models for these communities, CCRCs nest assisted living, nursing care, and hospice on the same campus with independent housing. Older adults choose a CCRC to preserve independence, take advantage of amenities living, and secure health care for future needs. Older adults move to assisted living within a CCRC when the independent home becomes too much for them to manage or their physical or psychological needs require support. They must plan and execute the move with the help of the facility and family, if available. The AL, while supporting choice as much as possible, still operates as a congregate setting in many ways, including group meals at set times and scheduled ADLS. An added challenge to transition includes cognitive functioning, both from a self-awareness perspective and having to adapt to others with cognitive impairment. When privacy, choice, dignity, and autonomy are supported, many residents in AL are very happy in their new space, calling it home.

Research studies indicate that the factors facilitating adjustment to a planned retirement community include perceived choice, preservation of relationships and social circles, familiarity with the community, meaningful activities, and perceptions of self and others (Cutchin, Owen & Chang, 2003; Schlossberg, 1981). However, there is little research that uncovers how older women perceive further relocations within the planned retirement community, triggered by either a health event or inability to manage in the independent setting (Shippee, 2009; Tracy & DeYoung, 2004; Cutchin, Marshall, & Aldrich, 2010). Therefore, the purpose of the body of work in this dissertation was to explore the experience of women who had transitioned to assisted living within a planned retirement community as well as two additional related topics: cognitive screening and the concept of assisted living as home.

Background

Cutchin et al. note that while there are only a few studies that examined factors affecting transition into CCRCs, health care security was the most important decision in making a move to a CCRC (2010). CCRCs are committed by regulation to minimize multiple relocations within settings, in keeping with aging in place principles and as a cost-effective strategy (Cohen, 2010).

Most residents in a CCRC begin with a residence in an independent home or an apartment. The initial move into the community is often seen as a planned and anticipated improvement in lifestyle, since home maintenance is included and the environment is designed to provide both privacy and social activities. CCRCs are structured with healthy living in mind because most CCRCs bear the increase in care costs when older adults transition to assisted living and nursing home settings. According to CCRC administrators, it is approximately 50% less expensive to the CCRC for residents to remain in their independent homes (Genworth, 2014). A successful outcome for CCRC administrators and residents would be for residents to maintain autonomy and independence by supporting a healthy lifestyle, improving ability to manage the chronic diseases that are common to the elderly, and providing cost-effective and preventative care driven by resident needs and preferences. Many older adults in CCRC utilize offered health care services such as the primary care facilities onsite.

Older single women in planned retirement communities may need to move to assisted living to better manage multiple chronic conditions, to receive assistance with activities of daily living and medication management, or as a result of an acute event. This decision is usually made with the input of the resident, family, primary care provider

and social worker, if the move is planned. However, unplanned transitions from one living situation to another are especially difficult, particularly when unexpected or not chosen by the elder (Chapin & Dobbs-Kepper, 2001; Krieger-Blake, 2006; Tracy & DeYoung, 2004). The stress of relocation may result in an increased risk of poorer health outcomes, isolation, and depression (Becker, 1997; Schlossberg, 1981; Schumaker & Meleis, 1994).

Having already downsized from the community into the CCRC, older women with chronic or acute health conditions may feel uncertain about their ability to remain in their present independent living homes (IL), causing what Becker refers to as a “period of limbo” (1997, p. 146). As older women pass through that period of limbo, they may need to move to an assisted living (AL) situation, where disruption occurs again. Transition encompasses more than a physical move to a facility, and includes possible changes in health, socioeconomic status, social support, and autonomy (Meleis, Sawyer, Im, Messias, & Schumacher, 2000).

It is important to understand both the personal and environmental factors that affect a person’s ability to rebalance after a move to assisted living. Transition theory has informed this investigator’s thinking about older adult women moving from independent to assisted living; therefore, this investigator acknowledges there may be complex factors involved in decision making about the move to AL. Additionally, the investigator has considered intrinsic and extrinsic factors that may explain why some older people manage chronic illness, disability, and loss of independence with grace and-acceptance while others are never able to adjust.

Saunders & Heliker (2008) used qualitative descriptive methodology to follow five older women through transition to assisted living in a single facility. Emerging themes included grief and difficulty with loss of independence as well as challenges with creating new relationships with other residents and staff. A move to assisted living could be perceived to be temporary since assisted living facilities may not be able to manage older women residents with multiple frailties or increasing debility, further increasing stress about another future relocation (Munroe & Guihan, 2005).

Research in this area has the potential to provide significant, positive, and cost-effective impact on the health and well-being of older adults and identify any missing services for those who wish to remain in their independent homes in a planned retirement setting, in keeping with the priority to age in place.

Aging in Place

In Western culture, people expect continuity in the flow of life (Becker, 1997). It is generally anticipated that people move through life stages and retire with resources and good health. Disruption occurs when life events fail to follow the planned path, and the restoration of equilibrium is important (Becker, 1997). The CCRC is designed to meet the expectations of older adults for an orderly retirement. Each level of care is carefully nested within the designed community to provide support as needed and remain as homelike as possible, minimizing the disruptions that occur when health conditions change. The hope of residents, families, and CCRC health professionals is that older adults will be able to stay as healthy as possible in their independent home for as long as possible, but when a move is required, the assisted living will become a comfortable home.

Aging in Place Defined

Aging in place is defined by the Centers for Disease Control and Prevention (CDC) as “the ability to live in one’s own home and community safely, independently, and comfortably, regardless of age, income or ability level” (CDC, 2013). While most adults prefer to age in their community homes (Ferrand et al., 2014), older adults may also choose to move to supportive retirement accommodations. In their review of overall measures of quality in AL, Hawes and Phillips (2007) described indicators that an assisted living facility should demonstrate as strategies to support of aging in place. Policies must clearly define the criteria to move a resident to higher levels of care, and there are strategies in place to manage residents with increasing levels of both physiological and psychological needs. The move to a higher level of care is consistent with aging in place when care designs support control, choice, and supportive relationships and reduce the functional barriers that created the need to move (Ferrand et al., 2014; Street & Burge, 2012).

Threats to Aging in Place

Threats to aging in place addressed throughout the study include inability to manage at home, failing health and frailty, and cognitive impairment. This study reflected the concerns expressed by older adults that their health or the health of a spouse will prohibit them from managing their lives at home or create burdens for their children (Groger & Kinney, 2006). With the increasing prevalence of cognitive problems and chronic diseases, future needs for long term care may be overwhelming for older adults.

Failing health and frailty. The absence of physical disability, arthritis, diabetes, and cognitive impairment, with moderate prediction for greater physical activity and

more social contacts, are predictors of healthy aging (Montross et al., 2006). In their review of 29 studies, Montross et al. found there were two groups of older adults who reported themselves as aging well: 1) those who did not experience disabilities from chronic disease, and 2) those who were able to maintain cognitive status, social functioning, and overall life satisfaction in the face of disabilities and increasing frailty.

Research that addresses decisions to move to higher levels of care from home, from acute care settings, and within institutions include increasing frailty, accelerated physical or cognitive decline, and an event such as a stroke, fall, or loss of a partner (Cheek, 2010; Perry, Anderson & Kaplan, 2013). Breakdowns in transitions from acute care to home or skilled facilities can contribute to overall decline in already frail adults and accelerate cognitive and physical decline, resulting in readmissions to acute care and relocation to a residential facility (Naylor, 2012).

There comes a point when older adults recognize and perceive their frailty and realize that staying at home may not be safe or healthy for them. Awareness is the first step in preparing for transition (Meleis et al., 2000), but the process is not always smooth and independence at home can work against the older person. Chores may not be done, risk of falling can increase, meals may not be prepared, and quality of life may be reduced (Cheek, 2010). In other words, the satisfaction of living independently at home is no longer present.

Cognitive impairment. Concepts of aging in place and successful aging generally incorporate normal cognitive function as a requirement for managing general activities of daily living in communities and residential care settings. As longevity increases, so does the prevalence of cognitive problems that impact the ability of older

adults to age in place, whether in an independent or assisted living situation (Laditka et al., 2009; Zimmerman, Sloane, & Reed (2014).

While it is difficult to accurately determine prevalence given the large numbers of people who have preclinical cognitive impairment or are undiagnosed (Cordell et al., 2013; Lin et al., 2013), data from the Aging, Demographics and Memory Study (ADAMS) suggest that in the US, 13.9% of people age 71 and older and as high as 45% of adults older than 85 have cognitive impairment affecting functional status (Alzheimer's Association, 2015). Because of the aging population, particularly the oldest-old (over 85 years of age), the annual number of new cases of Alzheimer's disease and related dementias is expected to double by 2050, and more than 50% of those person will be women (US Department of Health and Human Services, 2011) and residents in assisted living (Zimmerman et al., 2014).

Older adults are concerned about cognitive health (Laditka et al., 2009) and are very concerned about developing Alzheimer's disease. Cognitive impairment, to the degree seen in dementia, interferes with establishing and maintaining social relationships, a known factor for positive adjustment in assisted living (Street & Burge, 2012). Cognitively normal AL residents' avoidance of social contacts with people who have cognitive impairment can be problematic for positive adjustment in AL (Shippee, 2009).

Assisted living residences are a rapidly growing choice for older adults who receive assistance with medications and ADLS, including approximately 1,000,000 older adults with some form of cognitive impairment. Estimates of cognitive impairment among AL residents range from 34-71% depending on the level of (Zimmerman et al., 2014). Because AL residents with cognitive impairment generally need supportive care

as opposed to skilled nursing care, assisted living is the preferred setting. Dedicated memory care units in CCRCs are more likely to be located within the Skilled Nursing Facility than in than in assisted living (Zimmerman et al., 2014). Over time, the prospect of encountering older adults with dementia in AL is likely to increase, resulting in some cognitively normal older adults having reservations about moving to assisted living (Tracy & DeYoung, 2004).

The Concept of Home

Assisted living facilities are designed with home in mind. It is important to know what an assisted living is as a physical building with communal dining, activities, and supportive care services. Assisted living is meant to have a home-like décor and individual apartments with doors that can be locked. Residents choose their favorite furnishings to bring to this smaller space, and great effort is made to make this a home. As a center of daily life filled with memories and meaning, older adults have a great desire to remain at home, even in the face of increasing frailty (Gillsjö, Shwartz-Barcott, & von Post, 2011; Johnson & Bibbo, 2014). When health care providers enter a home, they enter a private space and may alter the balance of need for assistance with the desire for privacy and autonomy. The concept of assisted living as home can provide a framework of understanding so that caregivers can provide person-centered care that enhances freedom, choice, and privacy.

Dissertation Overview

The purpose of the dissertation study was to explore the lived experience of older single women who move from the independent living to the assisted living setting, both situated within a planned retirement community. The opportunity to deeply reflect upon

what it means to be an older woman moving to an AL setting provided insights as to how women perceived this relocation between two levels of a planned retirement community.

Three specific aims guided this study:

- 1) Gather the accounts of the lived experience of older women who move into assisted living from the independent setting of a planned retirement community.
- 2) Describe feelings the women had about their move from an independent to an assisted living setting.
- 3) Explore the descriptions of life in assisted living at the time of the interviews.

To further add to this experience, a comparison of brief cognitive screens that advanced practice nurses could use to support the health of residents of AL facilities was conducted. Finally, the concept of assisted living as home was explored as part of the aging in place purpose and strategy of CCRCs.

The qualitative work in the dissertation study was conducted in two traditional CCRCs known for their excellent facilities and comprehensive care. A hermeneutic phenomenological approach was used in order to hear and understand the voices of the women who lived this experience. Since participants with cognitive impairment were excluded from the study, it was important to dedicate a portion of the dissertation to examine this problem. A critique of brief cognitive screens was developed to provide recommendations for nurses who should assess for cognitive impairment within assisted living. One of the factors promoting satisfying transitions is the designation of *assisted living as home*. The concept analysis by Walker and Avant (2011) was employed to clarify this concept.

Phenomenological Research

Since there is little known about the relocation experience of older women who may make multiple moves within a Continuing Care Retirement Community (CCRC), a phenomenological approach to the research was chosen. Much has been studied about the impact of transitions from one setting to another (Becker, 1997; Meleis et al., 2000), but the essence of what it means to move again within a CCRC has not been explored deeply by health researchers. The hermeneutic phenomenology research question does not require the participants to provide opinions, views, or an interpretation of the lived event (Van Manen, 2014).

Hermeneutic phenomenology. Stories of aging are unique but are tied with the common threads of life. New and old fears, fresh loss, aging bodies, and time to explore life's meaning all characterize the experience of growing older. While most would agree that these are part of the normal experience of aging, the phenomenological researcher wants to "slow down and open up how things are experienced" (Vagle, 2014, p. 22). Hermeneutic phenomenology was well suited to explore what it means to be an older woman experiencing a planned or unplanned move within a community with its perceived losses and gains. During their interviews, participants were asked to describe in depth the experience of their move from independent to assisted living. In contrast to other approaches to phenomenology, hermeneutics is used when the researcher interprets the information from interviews. According to Van Manen (1990), the challenge of hermeneutics for the researcher is the reflection upon, the clarification of, and the explanation of the structure of meaning—in this case, the meaning of the experience of older women who moved into assisted living. The resulting themes gathered add to the

body of research that addresses how older women negotiate multiple moves during years of increasing frailty and possible end-of-life in assisted living.

Study Methods

Chapter Two employs a hermeneutic phenomenological research approach to explore the lived experience of 17 older women who moved from their independent condominium and apartment homes to the assisted living setting of two CCRCs, one in South Florida and one in Southern California. Data were collected and analyzed in keeping with ethical considerations crucial to ensuring successful rigorous study. The utilization of an approach that followed Van Manen's six research activities (1990) provided structure to address the research question. Reflections on Van Manen's Lifeworld Existentials (1990) guided the researcher to uncover three major themes from the individual interviews: *preplanning*, *executing*, and *adjusting* to the transition. The participants were familiar with the AL and most had their names on the waiting list if the need arose. Even with facility familiarity and assistance from family and staff, the move was challenging; further, adjustment was affected when participants had physical or sensory impairments.

Understanding the perspectives of the participants at stages of transition may lead to improvements in supportive individualized strategies by CCRC staff and administration at a vulnerable period of later life. Findings may also provide information for health care policy makers, assisted living administrators, and those seeking to improve the health of the rapidly aging population.

Comparison of Brief Cognitive Screens

Chapter Three of this dissertation presents a manuscript on the comparison of brief cognitive screens. This is an important component of the overall dissertation because of the prevalence of cognitive impairment in AL populations and the fact that cognitive impairment beyond normal aging is a common threat to aging in place in all settings. As a benefit for all Medicare recipients, *The Patient Protection and Affordable Care Act of 2010* requires an assessment for cognitive impairment be completed as part of the Annual Wellness Visit (AWV; Cordell et al., 2013). Chapter Three employs a critical review of the psychometric properties, usefulness, and limitations of six cognitive screens recommended for the AWV by the Alzheimer's Association and the GSA workgroup and included a discussion of how advanced practice nurses and nurses in assisted living could incorporate brief cognitive screens in primary care visits and in assisted living settings. Recommendations were suggested for the choice of a brief screen as part of a personalized health plan. An early diagnosis of cognitive problems allows the patient and family to have important conversations about what is important for future care, advance directives, and planning for legal and financial matters (Cordell et al., 2013). In assisted living, when residents have cognitive problems, support strategies and staff education can be implemented to maintain aging in place as long as possible (Gerontological Society of America [GSA], 2015).

Assisted Living as Home

Chapter Four presents a concept analysis on *assisted living as home*. The purpose of this concept analysis was to understand according to the literature how older adults may consider their assisted living residence as home, a seemingly important and desired outcome of transition. Using Walker and Avant's concept analysis framework (2011),

the literature published from 2009-2014 was reviewed. Thematic analysis was carried out to identify critical attributes, antecedents, and consequences. The critical attributes of being at home in assisted living were a *personal space*, a *private space*, and a *social space*. From the analysis, the concept of assisted living as home was demonstrated when residents were able to designate the assisted living as “home”, and desired to remain there as long possible. Satisfaction with the move, and the perception that one is “at home” is a good sign of adjustment to an AL setting (Cutchin et al., 2003).

Conclusion

Overall, participants in the dissertation study adjusted well to the assisted living setting in the CCRC; however, residents with sensory and mobility impairments struggled with integration, which is consistent with previous research about transitions. The cognitive impairment of other residents was of concern to them. As aging in AL progresses, increasing numbers of residents with cognitive problems and physical frailty may be challenged to designate AL as home.

The use of hermeneutical phenomenology brought the experiences of the participants to life through their interviews. The researcher employed Van Manen’s (1990) method to allow the themes and subthemes to manifest from reading and rereading of the transcripts. The themes were carefully considered by the researcher and reviewed by the dissertation mentor to ensure that the conclusions of the researcher were grounded in the data and the data was of rich quality.

The limitations of the study should be considered. The method of hermeneutic phenomenology requires data collection through the interaction of a participant and the researcher. Although the researcher was careful to maximize dependability, it is possible

that a different researcher or a different group of participants may have yielded different results. The participants were from homogeneous groups of women in similar CCRCs and were self-selected. It is possible that the participants may have chosen to tell their stories for their own purposes, such as reassuring the researcher of the excellence of the CCRC. There were only two opportunities for re-interview to clarify and expand on data. It is possible that re-interviews may have yielded further data.

This study has made a contribution to the knowledge about transitions to assisted living in CCRCs, a setting that will continue to be a residential environment for older adults. Nurses who provide care in AL can improve the transition experience by listening to residents and families about how their future health needs can be supported in IL and AL, how a resident considers the possibility of AL as home, and what psychological and social support would be helpful in the decision to transition. Cognitive impairment can complicate transitions; therefore, it may become essential to incorporate cognitive screening into nursing visits in assisted living. Once detected, education for patients, families, and staff may improve management of the environment to keep residents safe. Future research is needed to specifically investigate the factors promoting satisfying transitions in order to develop strategies to improve adjustment.

Chapter Two

Transitions to Assisted Living within a Continuing Care Retirement Community

Judith Scott, PhD(c), RN

University of San Diego

Transitions to Assisted Living within a Continuing Care Retirement Community

Judith H. Scott^{University of San Diego}

Hahn School of Nursing and Health Science

5998 Alcala Park

San Diego, CA 92110 USA

Corresponding author: Judyscott@pointloma.edu

Acknowledgements: Ann Mayo, RN, **DNSc; FAAN**, Patricia Roth, EdD, RN;
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Abstract

Transition from an independent living residence in a Continuing Care Retirement Community is a common but challenging move for older women, many of whom are often recently widowed. This study employed a hermeneutic phenomenological approach to explore how 17 older women experienced this transition. Three major themes surfaced from the interviews: *preplanning*, *executing*, and *adjusting* to the transition. Older women had foreknowledge of the on-campus Assisted Living and had their names on the waiting list. Even with facility familiarity and family and staff assistance, the move was challenging, and adjustment was affected when participants had physical or sensory impairments. Understanding the perspectives of the participants at stages of transition may lead to improvements in supportive individualized strategies by CCRC staff and administration at a vulnerable period of later life. Findings may also provide information for health care policy makers, assisted living administrators, and those seeking to improve the health of the rapidly aging population.

Keywords: Transition, Continuing Care Retirement Community, Assisted living, Older Women

Introduction

Currently, Americans older than 65 years of age account for 13% of the population. This percentage is expected to more than double in the next 10 years, burgeoned by the Baby Boomer generation, the largest generation in history (Lin & Brown, 2012). By 2030 there will be an estimated 72 million in this category, more than twice as many people than in 2000. The prevalence of Alzheimer's disease is expected to double by 2050, and more than 50% of those persons will be women (US Department of Health and Human Services, 2011), adding another layer of concern for planned communities.

The story of aging belongs primarily to older women, who were the focus of the study. They are both survivors and caregivers, often with health challenges of their own. Like their mothers before them, women will continue to outlive men. Women who are now middle aged can expect to take care of children and perhaps parents for many more years, facing greater challenges to health and socioeconomic status than ever before (Lin & Brown, 2012). The current population of women in assisted living in Continuing Care Retirement Communities (CCRCs) belongs to the group born before World War II. These women raised families; some were employed and lived through the Depression years. In general, this group of women moved to the independent setting of the CCRC while still married and planning ahead for security, amenities, and health care for their later years (Moen & Erickson, 2001). During this time of adjustment other transitions may be occurring, including the loss of a spouse and adjustment to widowhood, challenges with physical health, possible loss of prior social relationships, and distance

from adult children (Ewen & Kinney, 2014; Meleis, Sawyer, Im, Messias, & Schumacher, 2000).

Support for older adults' ability to age in place where they presently live is a national strategy as well as a philosophy (US Department of Health and Human Services, 2011). The *Affordable Health Care Act of 2010* includes preventative services and supports to help identify and manage chronic conditions so that older adults can remain in their communities for as long as possible. Aging in place does not preclude moving into age-restricted communities or supportive retirement communities. The move to a higher level of care is consistent with aging in place when care designs support control, choice, and supportive relationships and reduce the functional barriers that created the need to move (Street & Burge, 2012; Ferrand, Martinet & Durmaz, 2014). Aging in place can save money for older adults and for state and federal programs (Rantz et al., 2014).

Assisted Living in Continuing Care Retirement Communities

A few studies describe the decision-making and transition processes related to making the move to a CCRC or planned retirement communities (Groger & Kinney, 2006; Shippee, 2009; Waldron, Gitelson, & Kelley, 2005). Past studies examined the experience of moving into any type of assisted living (Cutchin, Owen & Chang, 2003; Fields, Koenig & Dabelko-Schoeny, 2012; Perry, Anderson, & Kaplan, 2013; Tracy & DeYoung, 2004), but only one study looked at the impact of moving to assisted living within a CCRC (Shippee, 2009), another move that may have adverse effects on a woman's sense of control and possibly her health (Meleis et al., 2000).

Older adults move to age-restricted CCRCs to simplify their living situation, maintain their freedom, satisfy their families' concerns about their safety, protect their

costs of health care, and possibly provide a secure setting for a surviving spouse (Groger & Kinney, 2006). The move can also extend an opportunity to enjoy many retirement activities and hobbies. Older adults make a choice to create a new independent living (IL) home within the planned community. In exploring the push and pull factors older adults experience when making a decision to move to a CCRC, Groger and Kinney uncovered an unexpected finding that some residents considered the move to the IL home an adventure rather than a final move (2006).

Older women, who often have been widowed while in the IL setting, may move to assisted living (AL) in response to an acute event, to manage multiple chronic conditions, or to receive assistance with activities of daily living and medication management. In CCRCs, assisted living is nested within the community. Residents in the IL often have friends and neighbors who have moved to AL, and they are familiar with the CCRC model.

Unplanned moves from one living situation to another may be difficult, especially when unexpected or not chosen by the elder (Krieger-Blake, L, 2006; Tracy & DeYoung, 2004). The stress of relocation may result in an increased risk of poorer health outcomes, isolation, and depression (Becker, 1997; Schumaker & Meleis, 1994). Several cross-sectional quantitative studies examine factors affecting older adults who move to nursing homes or assisted living from the community, but there are few studies that examine the transition into assisted living within a CCRC, where moves are a known possibility and the experience may represent risk or a benefit to health and resident well-being (Cutchin et al., 2003). Furthermore, there is limited research that uncovers how older women perceive relocation within the planned retirement community. If conducted, such

research may have implications for current and future movers (Cutchin, Marshall & Aldrich, 2010; Shippee, 2009; Tracy & DeYoung, 2004).

Transitions within Continuing Care Retirement Communities

Depending on the design of the CCRC, the type of care plan purchased, and the availability of home services, paid caregivers or family members may be able to attend and care for a resident in the independent apartment or home. In some CCRCs, the need for caregivers necessitates a transition to assisted living. The impact of moving from one level of care to another within a retirement community may not have been considered by the older adult resident when becoming part of the CCRC (Nygren et al., 2007). Hansen-Kyle, in a qualitative study of older women moving into a planned retirement community, pointed out that the participants fiercely guarded their independence and ability to control the move (2006). Shippee interviewed the residents of a Midwest retirement community who described the transition to assisted living as “going to the big house,” which they equated with a prison (2009, p. 422). Becker describes how women struggle to adjust to physical impairments that affect their ability to perform their daily routines and must plan and consider how much extra time these new realities will cost them in a day and what things they may leave undone (1997). When the loss of mobility is paired with a transition to a higher level of care, some older adults may begin to express a wish to die (Becker, 1997) or say they have moved to “a place to die” (Johnson & Bibbo, 2014, p. 59). Admission decisions forced by a health event or made without including the resident in the decision-making process can cause anger and may impair adjustment (Johnson & Bibbo, 2014).

Adjustment Following the Move

Important considerations for adjustment to assisted living are familiarity with the AL in advance, the establishment of resident and staff connections, resident-to-resident relationships, and the maintenance of the sense of home (Johnson & Bibbo, 2014, Dupuis-Blanchard, Neufeld, & Strang, 2009). When a resident moves to AL from IL, becoming at home in the new setting is an adaptive process of maintaining control of the overall move, perceiving the move as positive, retaining social and family ties, establishing new relationships and activities, and discovering that the new environment is balanced in terms of tangible and intangible resources (Perry et al., 2013). Tangible resources include items from home to decorate the new space, continued connections with family, and the maintenance and establishment of social resources. Intangible resources are internal individual resources that include perceptions of the move and keeping a healthy perspective of the home left behind.

Saunders and Heliker (2008) used qualitative descriptive methodology to follow five older women through transition to assisted living in a single facility. Emerging themes included grief and difficulty with loss of independence as well as challenges in creating new relationships with other residents and staff. A move to assisted living could be perceived as a temporary stop on the way to the nursing facility, since assisted living facilities may not be able to manage older women residents with multiple frailties or increasing debility, further increasing stress about another future relocation (Munroe & Guihan, 2005).

The purpose of this study was to explore the lived experience of older single women who moved from the IL to the AL setting, both situated within a planned

retirement community. Residents and their families, health care providers, and all staff who work with residents should be knowledgeable about this experience to provide proactive support of residents in transition. CCRC transitions have been viewed as one dreaded possible step toward the end of life or a supportive place to open a new chapter in older adults' lives. In addition to the managing the older adult's illness and wellness needs, ADL and safety concerns, several factors—including quality of life, adjustment to new routines, friendships, and personal meaning—can threaten or enhance well-being and should be considered during the first months of transition (Saunders & Heliker, 2008).

Materials & Methods

This study employed a phenomenological research approach to explore the lived experience of 17 older women who moved from their independent condominium and apartment homes in the independent setting of a two Continuing Care Retirement Communities. Individual interviews were conducted and Van Manen's research approach (1990; 2014) was employed to examine the transcripts, resulting in three major themes with subthemes.

Phenomenology suited the study purpose. While stories of transitions during aging are unique, they are tied with the common threads of life. Additionally, the approach was well suited to "slow down and open up how things are experienced" (Vagle, 2014, p. 22). Each participant's story offered a valuable experience to the researcher that provided the context for reflection (Van Manen, 1990).

Participants

Participants were recruited by flyer from two CCRCs—one in south Florida and one in southern California. Both are planned retirement communities that provide independent and assisted living, skilled nursing, rehabilitation, and hospice with life care contracts for residents. Both CCRCs are faith-based and have a church on the campus.

The Florida CCRC is a large campus adjacent to the ocean with 2,300 residents. Housing options include IL cottages, towers and independent homes spread throughout the campus, three assisted living facilities, and a medical health center that includes skilled nursing with a memory care unit, rehabilitation, and a medical clinic. Residents in all settings have access to several dining and recreational options. The Southern California CCRC is situated on a 28-acre campus with mountain and lake views. The campus includes several IL apartment buildings, an assisted living facility, a skilled nursing facility, a memory care unit on a separate wing of the assisted living, a rehabilitation center, and hospice integrated into levels of care. Both CCRCs offer transportation around and outside the campus.

Participants were familiarized with the study through distributed recruitment flyers, and staff assisted with determining that the women met inclusion criteria. Inclusion criteria were that women were over the age of 75, single, English speaking, had moved to assisted living from the independent home within a planned residential retirement community within the last 6-18 months, and had the cognitive capability to speak about their experiences in detail. Study oversight was provided by the University of San Diego Institutional Review Board. Informed consent was obtained from all participants, and pseudonyms were assigned to each participant to protect their identities.

Data Collection

Each participant completed an investigator-developed demographic form that captured age, race and ethnicity, marital status, whether widowed or otherwise single, length of time since widowed, educational level, length of residence in the IL, length of residence in the current AL, and number of local family members that were considered a resource.

Face-to-face, individual interviews using an interview guide with open-ended discussion allowed participants to describe their move and their adjustment to AL (see Appendix A). The interview questions were reviewed by an expert in gerontology and modified based on feedback and recommendations. All recorded interviews were conducted by the investigator in participants' apartments. A few written notes were collected during interviews to capture an impression, but not so many as to distract the participants. Notes were completed following each interview and included impressions about facial expression or non-verbal cues, tone of voice, or reference to photographs or writings mentioned by the participant. The study protocol included the opportunity to re-interview in person or by telephone.

Data Analysis

Hermeneutics was employed as the approach to interpret the meanings of oral recordings, observations, and written transcripts of the oral recordings. This process is not a mechanical process of coding or counting occurrences of words or phrases, but a complex process of grasping themes resulting from the participants' experiences (Van Manen, 2014). Van Manen's reflections on "lifeworld existentials" (1990, p. 101) guided the method to explore the phenomena arising from the interviews. As "universal themes

of life” (Van Manen, 2014), the concepts of relation, body, space, and time belong to all persons and help explain reality. Van Manen asserted that these existentials overlap and are not independent of each other but can be differentiated when describing the lifeworld of experiences (1990).

Review of audio transcripts and notes was conducted as soon as possible after the interviews and was followed by reflective writing and interpretation. Reflective writing included the investigator’s personal explanation of assumptions and knowledge held about the phenomena.

As described by Van Manen, three steps were used to generate the themes (2014). A holistic reading approach explored each transcript for overall meaning of the experience. Next, a selective reading approach included listening to tapes and reading transcripts for particular words or phrases that were illustrative of the concepts of relation, body, space and time, which was followed by a detailed reading approach where individual sentences and groups of sentences were considered to possibly represent study themes. Such sentences were highlighted and rationale and explanatory notes were generated for possible themes. Reflective and interpretive writing was performed during and after each step.

For the purposes of this study, *bridling* as described by Dahlberg (2006) was employed to gently and proactively steer the investigator away from preconceived ideas while not limiting forward motion (Vagle, 2014). Bridling was accomplished by journaling the investigator’s personal experiences about the study topic prior to the interviews and reflecting upon these writings.

Results

Nineteen residents indicated willingness to participate in the study, but seventeen participants completed interviews; two participants were excluded from the study because they had a difficult time articulating their transition experience and were unable to provide timeframes and locations of their moves. Two of the 17 participants were re-interviewed in person to further expand on emerging themes that were considered particularly relevant to the study.

All participants in this study were Caucasian and had a high school education or above. Their ages ranged from 84 to 94. All women had lived in their larger communities (specifically independent living) for an average of 10-11 years. All had recently moved into assisted living (less than 18 months), and half of the women had been in AL for 6-12 months. With the exception of one woman, the participants were widowed, with a range of 1 to 30 years since the passing of the spouse. Most of the women had at least one person that they could call on for support. A few participants had family out of state and chose to name the facility as their support.

Themes

Analysis of the data revealed three major themes surrounding the transition experience of the residents moving into AL: *preplanning*, *executing* the move by downsizing to the smaller apartment, and *adjusting* after the transition. Within these three themes, several subthemes were identified (Figure 1).

Figure 1. Themes and subthemes.

Preplanning: The anticipation of transition. Initially, the participants talked about their lives in IL and enjoying the amenities, friendships, and activities on a daily basis. When a health event affected the participant or spouse, themes of preplanning for the transition to AL surfaced in the transcripts. The subthemes of “*time to sign up*” and “*the writing was on the wall*” were salient in the planning stages of moving to AL, as several participants used both these phrases. When talking about engaging family in the discussion, “*don’t burden the kids*” was highlighted by the women as a strong desire to make their own decisions about their futures.

“Time to sign up.” This theme referred to putting one’s name on the waiting list for AL. The CCRC regularly offered tours of the AL and encouraged participants to sign up early. Harriet, widowed and resident in AL for a year, expressed the sentiments of several participants: “*What happened was that uh, somebody came around talking about assisted... saying of course that it was difficult and it took at least years and so I thought... Well, I don’t have anybody nearby to take care of me in case I get sick. I*

thought I better sign up for that.” Martha, resident of her condominium apartment in IL for more than 10 years, planned to stay after the death of her husband, but after two years had given up driving, and her daughter was pressing her to move. She finally determined that *“I’m in my late 80s. And uh, maybe I oughta reconstruct my life a little bit before something happens and someone has to do it for me.”*

The writing was on the wall. When considering the decision to move, *“The writing was on the wall”* was expressed in multiple interviews. Usually the participant or spouse was experiencing a health event or fall or noticed that another neighbor was moving to AL. Deborah described it this way: *“And then he got something wrong with his kidneys and the same doctor went back in there...and then that kidney began to fail. Well, we knew the writing was on the wall, both of us.”* Her husband passed on in hospice and Deborah moved to AL within a month.

Babs still missed her IL home after a year and described her dilemma when her name came to the top of the AL waiting list. Her husband had moved to AL for health reasons and had died there after a few weeks. She found managing her IL apartment alone was getting difficult:

Uh, I think the most challenging would be [was] for me to leave the island and coming over to [the AL].And I really wasn’t ready to make that move. I had several opportunities to go ... And I kept kinda putting it off, I thought, Well, I didn’t really wanna give up my independence.

She and others may have left unspoken what another participant, Bea, said about moving as *“the beginning of the end.”*

Not burdening the kids. *Not burdening the kids* meant that participants were very concerned about being dependent on their children, which became a subtheme. Some participants discussed the move jointly with their children, while others made the decision to move to avoid involving their children with decision-making or caregiving responsibilities. Esther, widowed for 30 years and an active and current court representative on her AL floor, had talked about moving to AL early on with her friends in IL. She expressed the feelings of several participants. “... *I can’t think of anything worse than uh, being dependent on them, but also being in the way...I think it’s unfair to them, actually.*” Maddie had chosen to move to the AL with her spouse but became widowed after six months. She added that her spouse and she had agreed that “*my children would be fighting over who is taking us...I didn’t want that.*”

Executing: Downsizing in transition. While some participants were satisfied with their move into the IL, many found the move to AL very challenging. The themes of *giving things away* and “*Hell on wheels*” defined the experience of downsizing and moving, and “*giving up the car*” meant a loss of freedom that accompanied the move.

Giving things away. Bea’s story echoed the sentiments of several participants whose experiences of downsizing included *giving things away*. Bea and her husband had enjoyed three years together in the IL. When he became ill and died, Bea, an artist, chose to stay in IL. After two years, her health needs began to limit her ability to paint and take care of her apartment. Smiling ruefully, she described the experience of knowing that her antiques were not valuable to anyone: “*you weren’t going to get anything for them.*” However, like many of the participants, she found satisfaction in being able to give specific art items to different children and grandchildren and allowing friends to come by

and choose a few things. Robbie, an AL resident for less than a year, was faced with the same experience and expressed satisfaction with planning the move. She felt well supported and had time to make choices about her giving things away: *“I loved downsizing....I loved seeing my things in my children’s homes.”*

Hell on wheels. Bea characterized the downsizing as *“Hell on wheels.”* Those whose husbands had passed or whose families were out of the area described the move as overwhelming. Janet, who had heard about this AL from others, hired three people to help her with the downsizing from her three-bedroom condo in the IL. Deborah, who moved only one month after husband died, had help from her daughter and reflected on downsizing as very hard work: *“Well, I just kept getting smaller and smaller!”* Participants described their family members and CCRC staff as helpful and essential to the large undertaking of deciding what to bring to the new apartment, which could be a studio or a one-bedroom apartment.

Participants who had little or no control over the move were less likely to express feelings of well-being. In their interviews, the women who were unable to participate in the downsizing expressed sadness at the loss of belongings. Furniture and art pieces were left behind, but sometimes these women needed items that helped with independence. When Harriet, who had very limited vision and hearing, moved into AL her sons came to help her in a hurried move, and she expressed regret that she did not have the opportunity to choose her belongings such as her “reading machine”: *“Lot of stuff I’d like to look at...a lot of stuff got left behind, but it’s gone now...went to the thrift shop.”* Sophie moved to AL quickly following a neurological event and had been in AL for just six months. She was grateful for the assistance of her daughter in the move but was still

considering what she left behind: *“I had a beautiful china closet with beautiful things in it, but I didn’t get any of it, I don’t know where it went.”*

Giving up the car. Some residents had not considered “*giving up the car*” in their downsizing. Driving was equated with the independent lifestyle, and the car enabled participants in AL to continue their activities outside the AL and the CCRC. Several participants who did give up driving discovered that they missed their cars. Maddie said, *“...But I miss it [the car]. Oh, oh I never realized, somebody had said to me, “Oh you’re giving your life away.”* Bea bemoaned the loss of her ability to drive within the last six months, *“and the hardest thing was (not) driving. All of a sudden I couldn’t drive anymore...”*

Adjusting: A response to transition. While some participants were able to adjust to their new living situation quickly, others found the adjustment to transition to take longer and be less satisfactory. Subthemes reflected the new home as *the place for me*, either pleased by or resigned to their lives in AL. They acknowledged *noticing their bodies* as healthy or weakening. Finally, *staying in control* of their daily activities was an important subtheme that was helpful to the participants who were adjusting to the major transition this move represents. Participants expressed the recognition that they had limited control over their futures.

The place for me. Participants adjusted to the new assisted living as the place for them to reside in terms of their apartment, staff support for ADLS, and health care. Some expressed pleasure that this new residence was overall homelike and they were happy with the new apartment, while others said that they were generally satisfied. Martha, who described her fond memories of her IL home, acknowledged she would never go

back. She said, *“I know in my heart of hearts that this is the place for me.”* AL as a “place for me” also included satisfaction with staff support for ADLS and medication management, meaningful activities, and the process of finding new resident friendships. Penelope, a retired nurse and resident for 15 months, said *“as our new residents come in, they are warmly welcomed...That surprised me, how quickly they join the family.”*

Harriet, however, was resigned to her life in AL as *the place for me*: *“I feel, considering my situation, uh, I couldn’t be in a better spot. And the people who work here are very considerate, very kind and uh, I have no complaints, I’m very fortunate.”* She was grateful she had a little peripheral vision remaining. She still managed the bus ride to the swimming pool twice a week and came to meals daily with her walker. She acknowledged her sons for their visits and phone calls but sounded very sad as she described how vision and hearing loss *“cuts you off from others”* and stated, *“...but, uh, my life has no purpose....I am just taking up space and resources.”*

Judith expressed some resignation after 15 months of experience since the move. She described herself as very independent prior to her neurologic event and described the move from IL to AL *“quite a change”* and very difficult:

... the only good thing is that I’ve helped a lot of people here....because it’s very difficult going from independent to assisted living. And I tell them, “Okay this is what happened, you just make the best of it,” and I said, “From my experience.”

Noticing their bodies. Aging bodies were acknowledged, with gratitude or with resignation and sadness, either as *“agile”* or *“falling apart.”* The women were aware that they were either very fortunate for their good health and mobility or were hampered by the need for assistive devices and staff assistance. Babs discussed her happiness at still

being able to drive a short distance to church, and said, “...*physically, you know, I can tell the difference. I’m certainly not getting any better, I know that... and it’s getting difficult for me to walk, you know.*”

Martha was grateful for her health and had respect for those who needed much more help than she did: “...*there are a lot of people older than I am...but I am very lucky to be as agile and as healthy as I am.*” The participants acknowledged that there were others with cognitive problems but they did not mind them at their tables and even offered guidance to anyone looking a little lost. Some of these healthier participants, surprised at the levels of disability they saw in AL, verbalized the feeling that the move may have occurred a little earlier than necessary, perhaps as a result of knowing that the waiting list for AL might be as long as two years.

Babs, who uses a cane outside her apartment, commented on her body aging: “*I am more wobbly than I was before.*” She is “*happy when I wake up in the morning, and I know it’s Monday....I’ll play Bingo... and tomorrow I will play bridge...don’t expect I will ever get better, but ...for what I have I’m very fortunate to even be here.*”

Harriet exemplified a body *falling apart*. Physical impairments and sensory losses made socializing both at meals and life in general much more challenging. Harriet had given up contributing to mealtime conversations and spent a great deal of time alone in her room, a disturbing finding. Harriet expanded upon how body impacted her experience of adjustment and the challenge of losses in her re-interview:

I sit at lunch generally alone, but occasionally with other women...But women’s voices are the first to go....and of course they don’t realize...It cuts you off from

the rest of people...I wish people would say their names when they see me....so I know who I am talking to....I mostly keep to myself.

Staying in control. Staying in control was represented by staying in charge of one's body, prioritizing ADLs, pacing activity along with choice of participation in the daily facility schedule, finding meaningful activities, and monitoring staff support. Janet was clear that she was in control by becoming stronger, taking physical therapy in her apartment daily. She said, *"I am determined [to stay in AL]...I will be okay here as long as I don't fall and hit my head."* Kitty's interview illustrated the process of staying in control and negotiating ADLs, medications, transportation, and AL schedules each day. She felt at her advanced age she could sleep late, *"have one meal at noon...take a good nap...This will be my home."* Penelope had taken on organizing the small library at the AL and was quite pleased with the new occupation of doing jigsaw puzzles with a new friend. When describing how she managed her time, Carol held out a beautiful hand-knit baby sweater and said, *"I don't do anything constructive.."* She explained that she no longer knit to sell the pieces in the gift shop.

Finally, some participants were concerned they were paying too much for their medications. Edna used her sharp attention to detail to be certain that she and others were in control of the care they received: *"But last month I caught them and they neglected to put in three pills...Don't just give me 'Oh she's old.' And [they say] we are the ones that make mistakes."*

When asked for any final comments, discussions about the future included the recognition that staying in control might not be possible. Bea's comments were representative of many participants: *"I am not thinking about it...I take one day at a*

time.” Leaning in, she quietly shared that the “next step” was the nursing home, “*Hell on earth,*” which some had labeled similarly. Several had personal experience recuperating from health events in the nursing facility or had a spouse that passed away there, and they expressed strong preference for staying as long as possible in AL. “*I am leaving here feet first*” was expressed by one participant. Martha summed up the discussions about the future in a resigned tone: “*when that time comes, I will probably be only one voice in what really happens to me.*” Judith retained a sense of humor about her body and her future, saying “*I could konk out any time!...oh it’s going to happen!*” Maddie and Corrie expressed their faith for the future, hoping God would grace them with a peaceful exit from this world. Corrie put it this way: “*I thought I could probably skip by the (sick) phase...I am 100 you know.*”

Conclusion

The participants described their transition from the IL to AL setting in the CCRC. The data were consistent with other research that highlights the importance of perceived choice in a relocation move for older adults (Street & Burge, 2012; Ferrand et al., 2014). Overall, planning and executing the downsizing move with support from the CCRC, family members and friends was expressed positively. The women in this study readily consented to share their stories and were eager to add comments and advice to support the transition for others. One common encouragement was, “*Oh she should sign up now!*”

Residents in IL often personally know neighbors who have moved to AL or have cared for a spouse there. Since residents were part of the CCRC community for ten years on average, this conversation was often a discussion among friends, children, and

representatives of the CCRC, which may have been helpful in the decision-making process. Meleis et al., in development of transition theory, highlighted the importance of “awareness” of transition in adjustment to the experience (2000, p. 18). Some participants were encouraged or coaxed by their children to sign up for AL, while others made it very clear that the decision to move was exclusively theirs. There was anxiety expressed when their names came to the top of the waiting list and a choice needed to be made. Babs and Bea voiced that making this decision might be “the beginning of the end,” of giving up the car and losing independence.

Study findings may support that when residents intersect with health care providers and social workers, there may be opportunities for residents to receive support to discuss a) how future health needs can be supported in IL and AL, b) what independence means to the resident considering the move, and c) what psychological and social support would be helpful in making this difficult decision. Coordination during the planning stage of the move could reduce the stress of downsizing and moving and improve resident confidence and competence.

When a resident moves to AL from the IL, becoming at home in the new setting is an adaptive process of maintaining control of the overall move, perceiving the move as positive, retaining social and family ties, establishing relationships and activities, and discovering that the new environment is balanced in terms of tangible and intangible resources (Perry et al., 2013; Schlossberg, 1981). Tangible resources that supported the move included items brought from the previous home to decorate the new space, continued connections with family, and the maintenance and establishment of social resources, like staff relationships or tablemates at meals. Many participants expressed

satisfaction and pride at the choice of possessions they brought as the right amount, fit well in their space, and were the most important items. They related their process of successful integration into congregate dining and found new activities and friendships. Participants who described the staff positively and who were able to find friends at mealtimes expressed contentedness and adjustment. “Joining the family” is a predictor of health and adjustment (Ferrand et al., 2016; Street & Burge, 2012).

Intangible supportive resources were those that were individual and internal and included positive perceptions of the move, a healthy perspective of the home left behind, and the establishment of a sense of belonging in the AL. Some women had found meaningful volunteer activities or enjoyment in working on jigsaw puzzles and attending bible studies or participating in resident council meetings. Others who could not volunteer or participate because of physical or sensory impairments did not find activities that engaged them in the AL and expressed some loneliness. Several women mentioned how their faith practices and their belief in the presence of God supported their new day-to-day life and ensured their future. Since meaningful activity is often connected to satisfaction and wellness, exploration of past and current talents and skills should be part of the overall assessment of a resident entering AL.

Most of the participants considered the new residence in AL as a final home. Participants were clear in their stories that their time in IL was independent and happy, but a chapter fading into the past. It was clear that they did not want to move beyond AL to the skilled nursing facility. Participants from both sites were generally satisfied with the new assisted living as the place for them to reside in terms of their apartment, staff support for ADLs, and health care. They were taking their days one at a time, either as a

blessing, or as one less day that they were waiting to go on to final rest. There were concerns expressed about the need to move to the skilled nursing facility, which was seen as a last resort and even termed “hell” in some instances. When asked what things would result in such a move, most agreed that a fall, a stroke or memory problems would be possible reasons. As Janet said, “*Don’t fall.... And use your brain!*”

In keeping with research that describes the difficulty older adults have with giving up driving (Adler & Rottunda, 2006), the loss of driving privileges was repeated in several interviews. Representative of loss for many was “*giving up*” the car. Participants expressed frequently how possession of the car and the ability to drive was equated with independence, and some were surprised at how much they missed that freedom. Others reported that they were still driving and this was a source of pride and continued competence. Several participants wished the CCRC would allow them to keep their car on the property, even if they were not driving, so that family members could use it when visiting. Keeping safety as the priority, current policies about car ownership and parking in such settings might be re-examined with input from residents.

Healthier active participants expressed some surprise at the levels of disability they observed in AL, resulting in gratitude for their personal health and respect for those who needed more assistance. They were both aware and supportive of residents who were having mild memory problems. Two participants expressed feeling they had moved in to AL a little earlier than necessary and did not feel as engaged in the AL. They preferred and were satisfied with activities and relationships in the larger CCRC community and were still driving. These findings support other studies that document that full integration into the AL is related to the building of relationships with residents

and staff, and that this integration was likely to take place over time (Street & Burge, 2012).

Participants who had physical or sensory limitation or who had moved because of an acute event were more challenged in adjustment. Harriet verbalized poorer well-being and loneliness. She was missing her possessions that disappeared in the move, and while she was making the best of what vision she had, she was experiencing isolation.

Residents with limited mobility or sensory loss may benefit from extra attention and time spent listening to their stories, planning and downsizing, and providing extra attention to their possessions, particularly those items that supported their sensory losses, as well as other physical and emotional needs. Because they may not be able to join in with others in volunteer or social activities, these residents are at higher risk for loneliness, depression, and poor adjustment (Meleis et al., 2000).

It is worth noting that at the time of moving to AL, some participants were living with recent grief from losing a spouse. Becker referred to transitions characterized by loss as “disruption” (1997). The participants who were grieving had the added stress of losing a partner of many years, affecting their perceptions of the move and the length of time needed to adjust. One participant stated that she could never be quite happy again. Schlossberg, who created a model of transition to help explain this very complex phenomenon, called for special attention for all stages of transition when a resident is still grieving from loss (1981). Chaplain support was available at both sites, but additionally, nursing and social work staff as well as volunteers could easily offer support by lending a listening ear, especially early in transition.

There are limitations of the study that should be recognized. First, not all questions on the interview guide could possibly elicit the full range of the experience for each participant. Another limitation of the study was the homogeneity of the participants, who were all Caucasian, financially stable, and well educated. The two CCRCs were considered to be examples of the best communities in their respective areas, so participants may not have been as likely to be critical of their physical living situation as they may have been in other settings. Finally, while discussions of spirituality occasionally surfaced in interviews, the fact that the CCRCs were faith-based may have influenced how the residents perceived their experiences and thus is a topic for future development.

Some participants may have painted a rosier picture of the move and adjustment to AL portrayed in an effort to assure that the researcher understood that the CCRCs were supportive and good living situations, despite reassurances that the researcher was not present to judge either the participants or the CCRCs. The participants were also eager to point out the things they were able to do (*“I still drive”*), and that they had still their *“wits about them.”* One participant wanted the investigator to know that she *“used her head for something more than a hat rack”* and another that *“I am not a crazy old lady,”* perhaps to combat perceptions of ageism that could have been a concern.

Residents with impaired mobility and cognitive and sensory impairments struggled with integration into the AL. As aging in AL progresses, increasing numbers of residents may not fit in with those who are more agile and competent. This is an area that calls for further investigation of support strategies for these residents who may feel

marginalized. There is a need to support residents who may be actively grieving the loss of their spouse or may have challenges establishing new friendships.

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Chapter Three

Instruments for Detection and Screening of Cognitive Impairment for Older Adults

in Assisted Living Settings

Judith Scott, PhD(c), RN

University of San Diego

Instruments for Detection and Screening of Cognitive Impairment for Older Adults in
Assisted Living Settings

Judith H. Scott, PhD(c), RN

University of San Diego Hahn School of Nursing and Health Sciences- PhD in Nursing
Student

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Abstract

The Patient Protection and Affordable Care Act requires an assessment for cognitive impairment is completed as part of the Annual Wellness Visit (AWV). Nurse practitioners are in a good position to incorporate brief cognitive screens into the AWV. An early diagnosis of cognitive problems allows the patient and family to have important conversations about what is important for future care and advance directives and to plan for legal and financial matters. Using the results of a cognitive screen may allow primary care providers to “kickstart” these difficult conversations.

Numerous cognitive screens are available for use; however, primary care providers may not be aware of the differences between many screens. This article examines the psychometric properties, usefulness, and limitations of six cognitive screens.

Introduction

Early identification of cognitive impairment in older adults is important given its prevalence in community and residential settings, including assisted living (AL). In 2010 there were 735,000 residents living in AL, with 90% of residents over age 65. Cognitive impairment may progress to Alzheimer's disease (AD) and early identification by nurses and nurse practitioners while older adults are living in AL could result in improved plans of care, safety in AL and quality of life and reduced caregiver burden and cost savings (Cordell et al., 2013; Zimmerman, Sloan & Reed, 2014).

Background

Concepts of aging in place and successful aging generally incorporate normal cognitive function as a requirement for managing general activities of daily living in communities and residential care settings. As longevity increases, so does the prevalence of cognitive problems due to normal aging, mild cognitive impairment (MCI), and Alzheimer's disease and related dementias (ADRD). While it is difficult to accurately determine the prevalence of cognitive impairment (Cordell, 2013; Lin et al., 2013), data from the Aging, Demographics and Memory Study (ADAMS) suggest that in the US 13.9% of people age 71 and older and as high as 45% of adults older than 85 years are cognitively impaired (Alzheimer's Association, 2015). Zimmerman et al. estimate that seven out of ten older adults in assisted living have some form of cognitive impairment, ranging from 29% with mild impairment and 23% with moderate impairment to 19% with severe impairment (2014).

Assessing Cognition

Accompanying increasing public awareness is an emerging requirement for health care professionals working to assess the state of cognitive health among their primary care patients, including those who reside in assisted living facilities. However, recent research is already demonstrating that during routine assessments providers do not recognize cognitive impairment in as many as 27-81% of patients (Cordell et al., 2013; Lin et al., 2013).

A number of complex reasons may be in play to hamper the provider's ability to recognize cognitive impairment. Beginning with the patients and their families, individuals may lack knowledge about what is "normal" for different age groups, compounding the provider's likelihood of missing signs of cognitive impairment (Yokomizo, Simon, & Bottino, 2014). The complexity of symptoms and etiologies make misdiagnosis a real possibility, and this is a significant source of distress for patients (Borson et al., 2013). When the diagnosis is accurate, the stigma attached to a problem of cognitive impairment is also a concern for patients and family members (Ismail, Rajji, & Shulman, 2010).

Overall, the literature supports the importance of detecting cognitive impairment in primary care; however, there is no consensus that early detection and intervention improves patient and caregiver outcomes (Lin et al., 2013). As early as 2003, the US Preventive Services Task Force (USPSTF), an advisory board of nationally recognized experts in primary care, geriatrics, and behavioral health, considered universal screening of older adults for cognitive impairment but did not endorse *routine* screening for all older adults.

Annual Wellness Visit Assessment of Cognitive Status

The Annual Wellness Visit (AWV) was added as a new Medicare benefit with the passage of the *Patient Protection and Affordable Health Care Act of 2010*. The Centers for Medicare and Medicaid Services (CMS) requires detection of cognitive impairment in addition to a routine review of history, physiological assessment, list of medications and providers, and suggested preventative care. The CMS has not recommended a particular instrument for detection of cognitive impairment, leaving it up to primary providers to decide how to incorporate assessment into the AWV.

The CMS has noted that the lack of guidelines for detection of cognitive impairment may hamper the full benefit of the AWV (Cordell et al., 2013) and has therefore sought input from the National Institute on Aging (NIA) regarding evidenced-based instruments that might be used in the AWV (Gerontological Society of America [GSA], 2015). Concurrently, the Alzheimer's Association convened the Medicare Detection of Cognitive Impairment Workgroup (MDCIW) to develop a recommendation for cognitive screens to be used in primary care. The GSA Workgroup on Cognitive Impairment and Earlier Diagnosis published their recommendations for conducting a patient visit that includes an evaluation to detect cognitive impairment using a brief screen (2015).

Primary Care Providers are Called to Assess Cognitive Status

The MDCIW and GSA workgroups have recommended that primary providers incorporate brief cognitive screens into the AWV “to increase both detection of cognitive impairment and earlier diagnosis of dementia, leading to more appropriate diagnostic medical care and increased referrals for support services” (GSA, 2015, p. 4). The

primary aim of the work was to identify cognitive screens that can be administered in less than five minutes, are free of charge, have sound psychometric properties, and produce valid assessment data in Medicare populations (GSA, 2015). The USPTF suggests that the cognitive screens used in the AWV be part of a “stepwise approach” (Lin et al., 2013, p. 612) to determine criteria for incorporating cognitive assessment into the wellness visit. The MDCIW agreed that informal observation by the primary provider was not sufficient to determine impairment.

The purpose of this paper is to provide a review of the brief cognitive screens recommended for the AWV by the Alzheimer’s Association and the GSA workgroup, discuss the incorporation of brief cognitive screens in primary care visits, and make recommendations for the use of brief cognitive screens as part of a personalized health plan. The engagement of the primary provider with patients, family, and caregivers is important for screening, follow-through, and coordination of resources for findings of cognitive impairment.

Method (Search Strategies or Design)

Articles that discussed brief cognitive screens were identified from databases (PubMed, CINAHL) using the key terms *brief cognitive screening instruments*, *older adults*, and *cognitive decline*. In addition to the published articles by the authors of the screens, the National Institute on Aging makes available a searchable database of 116 screens for cognitive impairment that was useful to find brief cognitive screens meeting criteria appropriate for use in primary care (NIA, 2014). Each of the screens chosen for review followed the criteria suggested by Milne (2008) as described by Yokomizo et al.

(2014), which included practicality, feasibility, applicability for use with older adults, and psychometric properties.

Select screens included in this review were the Mini-Mental State Examination (MMSE; Folstein, Folstein, & McHugh, 1975), the General Practitioner Assessment of Cognition (GPCOG; Brodaty, Low, Gibson, & Burns, 2006), the Memory Impairment Screen (MIS; Bushke et al., 1999), the Mini-Cog (Borson et al., 2000), the Eight-Item Interview to Differentiate Aging and Dementia (AD8; Galvin et al., 2005), and the Montreal Cognitive Assessment (MoCA; Nasreddine et al., 2005). Each cognitive screen was reviewed to examine psychometric properties including method of administration, scoring, validity, reliability, sensitivity, specificity, usefulness, and limitations, using the original articles and related studies published on the instruments. A detailed summary of the characteristics of each screening instrument is included in Table 1, and the psychometric properties are described in Table 2.

Review of Brief Cognitive Screens

Brief cognitive screens may address questions that both patients and caregivers may have about memory. Brief cognitive screens include patient only, informant only, or a combination of patient and informant data. Suitable screens (less than 10 minutes, preferably less than 5 minutes) should be reliable and produce valid data. The screen must have high sensitivity, meaning that it identifies patients who have mild cognitive impairment, and high specificity, meaning that it identifies patients who are not likely to have cognitive impairment. Brief cognitive screens should be low or preferably no cost, easy to administer, acceptable to patients, and free from cultural, educational, and language biases (Cordell et al., 2013; GSA, 2015). These instruments may differ in terms

of what domains are covered, who provides data (patient or an informant), necessary permissions and costs for use, and administration procedures. Instruments may be affected by patients' cultural background, educational status, and verbal, reading, or writing abilities. In addition, brief screens should perform well against the widely used Mini-Mental State Examination (Ballard et al., 2013). As part of the AWW or any evaluation, it is important that the provider be comfortable with a screen that takes 5-10 minutes to administer. Screens presented in this discussion have training options available from the Cognitive Assessment Toolkit by the Alzheimer's Association and some instruments have websites for training purposes.

Mini-Mental State Examination (MMSE)

The Mini-Mental State Examination was developed for use in clinics by primary care providers in 1975 by Folstein et al. While there were other, lengthier cognitive batteries available at that time, the MMSE was developed as a clinically appropriate and relatively brief screen to give a practical assessment of change in cognitive status in older adults in inpatient settings (Nasreddine et al, 2005). The screen includes 11 items for a maximum possible score of 30 points. The items cover a wide range of cognitive domains and can be administered by primary care providers in approximately 10 minutes.

The MMSE was originally validated in a group of 206 subjects with many levels of cognition and included 63 subjects with normal cognition (Folstein et al., 1975). In a systematic review, Lin et al. (2013) determined a pooled sensitivity of 88.3 (81.3-92.9) and pooled specificity of 86.2 (81.8-89.7) for the MMSE. Reliability was established using test-retest reliability (0.89) and between examiners (0.98), and validity was thoroughly tested against the Wechsler Adult Intelligence Scale (Folstein et al., 1975).

The MMSE has been the most widely used screen available in multiple languages and therefore has a wide range of utility. It has been recommended to rule out dementia in community and primary care populations (Ismail et al., 2010); however, the MMSE may not be able to accurately discriminate normal cognitive function from mild impairment due to the influence of educational level and cultural biases, called the “ceiling effect” (Ismail et al., 2010; Nasreddine et al., 2005; Yokomizo et al., 2014). Subjects with higher levels of education find the test is too easy, resulting in reduced sensitivity, and too difficult with less-educated subjects, resulting in reduced specificity, a false positive result for cognitive problems (Cordell et al., 2013; Galvin et al., 2005; Nasreddine et al., 2005). Registration and purchase are required per the copyright, which may be prohibitive for some organizations.

General Practitioner Assessment of Cognition (GPCOG)

The GPCOG as a screening instrument has both an informant and a patient portion. The GPCOG was developed for primary care by Brodaty et al. (2002) from three other validated instruments and can be administered in less than 5 minutes, with another 1-2 minutes for the informant portion. The GPCOG informant screen may be completed on the phone, in person, or concurrently with the patient assessment. The patient screen includes 6 cognitive items: an information statement for later recall (a full name, street and city address=0 points when first read), time orientation (1 point), clock drawing (1point), a current events question (1point), and a repeat of the recall item (4 points), for a total of 9 points. The informant interview asks 6 questions about “how the patient is compared to when she/he was, say 5-10 years ago” for a total of 6 points.

Total scores are calculated for each section of the instrument. Neither section of instrument has subscales. The maximum score for both screens is 15 points. Patients who receive the maximum total score of 9 on the patient screen are considered negative for cognitive impairment and the informant portion of the test is then not necessary.

The GPCOG was originally validated in a clinical sample of community-based patients with memory complaints (Brodaty et al., 2002). The data was validated in French, Chinese, and Italian versions using the MMSE (Brodaty et al., 2002; Cordell et al., 2013). Yokomizo et al. (2014) found that the GPCOG had the best predictive values for patients in community settings. Tests of reliability included interrater, intraclass correlation (ICC), and test-retest, which ranged from 0.75- 0.87. Internal consistency was strong (Cronbach's $\alpha=0.84$).

The GPCOG is also sensitive (0.82) and specific (0.83) for the combined patient and informant sections (Brodaty et al., 2002). The strengths of the instrument are similar to the MMSE when both the patient and informant tests are used (Brodaty et al., 2002; Ismail et al., 2010, Lorenz, Scanlan, & Borson, 2002). It is simple to administer and score. The use of the informant interview may be very helpful when there is a family member or caregiver who has concerns about the patient's cognition (Cordell et al., 2013). There is no cost associated with instrument use, and the website provides a demonstration of use and scoring for the provider.

Cordell et al. (2013) determined that the GPCOG is relatively free from education or cultural biases, but Lorenz et al. (2002) did not; they noted that one of the screens used to develop the GPCOG was biased by socioeconomic factors and urged caution when interpreting results. Since the sensitivity and specificity are only improved with both the

informant and patient interviews, another screen may be more suitable if there is no informant available (Brodaty et al., 2002).

Memory Impairment Screen (MIS)

The MIS is a verbally administered instrument validated in primary and community settings (Cordell et al., 2013). The Memory Impairment Screen (MIS) was developed by Bushke et al. as a four-minute, four-item, delayed and cued-recall test of memory impairment. The researchers deemed this a screening test for “Alzheimer’s disease and other dementias” (1999, p. 231). Subjects are given the names of items and are told there are four different established categories (e.g., animal, city, vegetable, and game). The assessor asks the patient to repeat the name of the item and identify the category (e. g., checkers, a game). Next, before asking for recall there is a distractor task, such as counting backwards or spelling for two to three minutes. Following the distractor task, the patient is asked to name the item in each category for free recall. When the patient is unable to recall any more words, cued recall is used (e.g., “What was the game?”)

Free recall accuracy receives 2 points for each of the 4 words for a total possible range of 0-8. Patients who are able to recall the 4 words receive a score of 8. Patients who need cueing for recall receive 1 point for each recalled word for a total of 4. Points are summed for the total score; there are no subscale scores. Patients who receive a score of 5-8 are considered to have normal cognition. Bushke et al. (1999) recommended a cut-off score of 4 for possible cognitive impairment.

Kuslansky et al. (2002) concluded that the MIS had high discriminative validity as a screening test when compared with a conventional three-word recall, as is used in the

MMSE. Alternate forms reliability of the MIS was determined to be satisfactory ($r=0.69$) by administering two forms to 429 participants. The MIS demonstrated high internal consistency/reliability (Cronbach's coefficient alpha 0.67). The sensitivity and specificity at the cut-off score of 4 ranged from 0.80 and 0.97 respectively for discriminating cognitive impairment versus normal cognition (Bushke et al., 1999; Kuslansky et al., 2002).

This instrument is publicly accessible, easy to use and score, and can either be self-administered or read to a patient, removing a literacy requirement. As an interview, it is also appropriate for those with motor impairments because there is no writing or drawing. Designated as a good choice for the AWW by the Alzheimer's Association (Cordell et al., 2013), the test is acceptable to patients (Ismail et al., 2010) because the use of category cues improves attention and increases retrieval (Buschke et al., 1999). MIS performance is independent of age, depression scores, culture and education.

Limitations for the MIS include having to be familiar with the word list options, which introduces bias (Kuslansky et al., 2002). The MIS is primarily a test of memory. It does not test visual spatial skills or executive function, which may be important in determining daily function and decision-making (Ismail et al., 2010; Cordell et al., 2013; Galvin, 2005). Bushke et al. developed this instrument for "screening for AD and dementia" (1999, p. 231), but it is important to note that this instrument cannot specifically screen for dementing diseases, but may be used to as a screen for cognitive impairment due to any causative source (e.g., vitamin B12 deficiency). Further assessment is always required to determine the source of a patient's cognitive impairment.

Mini-Cog

Borson et al. (2000) developed the Mini-Cog to assist with the discrimination of different cognitive changes that occur due to dementia. The screen was also developed to improve upon the Clock Drawing Test (CDT), which as a single screen has limitations in sensitivity and predictive validity (Ismail et al., 2009). The instrument combines two simple cognitive tasks: a three-item recall and the CDT. The patient is asked to repeat and remember three unrelated words from a choice of six validated three-word lists and then completes the CDT before recalling the word list (Borson et al., 2000).

The total possible score for this instrument is 5. Patients who are able to perform recall of the three words would receive a score of 3 (Borson, 2002). An accurate CDT would receive a score of 2. The clock circle may already be drawn on the paper and handed to the patient. The patient should “set the time” to read 10 minutes after 11:00, or 20 minutes after 8:00 (Ismail et al., 2009, p. 114). Because the directions can affect the psychometric properties, administrators must be very specific in order not to give clues to the patient. Recall of 1-2 words with an accurate clock drawing test (score of 2) would receive a score of 3 or better and would be considered negative for impairment. If a patient makes errors in the CDT (score of 0) and is unable to recall words, the patient may have cognitive impairment and needs further assessment.

Borson, Scanlan, Chen, and Ganguli (2003) validated the Mini-Cog in a random sample of community living older adults and found it performed well against the MMSE and is comparable to standardized batteries like the MMSE in predicting cognitive problems (Cordell et al., 2013). Sensitivity of the Mini-Cog ranges from 76 to 99% and specificity from 89 to 93% (Borson et al., 2002; Holsinger et al., 2012; Ismail et al.,

2012; Kaufer et al., 2008). Assessments of reliability are limited. In one Korean translation of the Mini-Cog, test-retest reliability was deemed “reasonable” over four weeks ($r = 0.85$, $P < 0.01$; Doerflinger, 2007).

The Mini-Cog is easily administered, free from educational, language, and cultural biases, and psychometrically comparable to the MMSE (Borson et al., 2003; Cordell et al., 2013; Ismail et al., 2010). The Mini-Cog may be used in acute settings where dementia versus delirium is in question (Doerflinger, 2007; Mion & Sandhu, 2014). There is a free demonstration of the Mini-Cog through the John A. Hartford Institute of Geriatric Nursing “Try This” series (Doerflinger, 2007). Training for use of the Mini-Cog is optional, but a wide range of professionals can administer this instrument in about three minutes. Patients would not likely object to this test as a simple recall in any setting.

Limitations of the Mini-Cog include needing the physical and executive ability to hold a pen and draw a clock face. Borson et al. (2003) refers to several studies that indicate there are differences in how the CDT may be administered and scored, which can affect the sensitivity of the test. Scoring the Mini-Cog could be problematic, since different word lists can affect recall. For example, some lists may be easier than others to remember, depending on the background of the patient. As in all word recall tasks, it is important for the administrator to wait the appropriate time for the patient to recall. As with other brief cognitive screens, generalizability to different populations (i. e., those with semantic dementia versus frontal temporal dementia) may be affected by the prevalence of different cognitive impairments (i. e., word finding versus executive function) in any specific population. Holsinger et al. (2012) noted that there are other

screens with better sensitivity and specificity than the Mini-Cog; however, they require a much longer administration time.

Eight-Item Interview to Differentiate Aging and Dementia

Galvin et al. (2005) developed the Eight-Item Interview to Differentiate Aging and Dementia (AD8) as an informant interview to assist with discriminating normal aging from very mild cognitive impairment. The researchers were concerned that other brief screens were weighted towards memory deficits. Galvin et al. preferred informant-based interviews to identify individuals with mild cognitive problems because they have documented face validity and are well established in clinical research, citing the Clinical Dementia Rating (CDR) and the Informant Questionnaire on Cognitive Decline (IQCODE) as evidence.

The eight questions in the interview are more comprehensive in addressing memory, orientation, judgment, and function and in assessing the ability of the patient to remember appointments, keep track of current events, express level of interest in hobbies, and answer questions about changes in abilities (e. g., changes in the ability to balance a checkbook). A “yes” answer is scored 1 point. Normal cognition is determined to be in the range of 0 to 1, and 2 or greater may signify cognitive impairment. The AD8 takes three minutes to administer, is available in the public domain, and does not require extensive training. In the absence of an informant, the AD8 may be administered to a patient (Galvin, Roe, & Morris, 2007). The instrument may be self-administered or read to the informant or patient.

The informant battery was validated against the Clinical Dementia Rating (CDR) assessment (2005). The AD8 correlated strongly with CDR scores. Chin et al (2013)

validated the AD8 in the Chinese patient population, and the AD8 has been validated in several other languages. Carpenter et al (2011) validated the AD8 in the emergency department population. Galvin reported sensitivity between 0.74 -0.85, with specificity at 0.86, with a cut-off of two items. However, when administered to the patient only, sensitivity was 0.59 and specificity was 0.65 (Dong et al, 2013).

Several tests of reliability have also been reported. Internal consistency yielded a Chronbach's $\alpha = 0.84$ (Galvin & Zweig, 2013). Both in-person and phone administration demonstrated equal reliability (0.65), and interrater reliability was very good (0.80) (Galvin, 2006).

Montreal Cognitive Assessment (MoCA)

The Montreal Cognitive Assessment (MoCA) was developed over five years as a brief screen for mild cognitive impairment (MCI) and has been determined to be comparable to the MMSE. This paper-and-pencil instrument requires 10 minutes for administration. Six subscales measuring short-term memory, visuospatial, executive, attention, language, and orientation are summed for a total possible score of 30 points. Patients who receive a score of 27-30 are not considered to have cognitive impairment. Patients who receive a score of 18-26 ought to be considered for possible mild cognitive impairment, and patients who receive a score of 10-17 should be further evaluated for moderate cognitive impairment. The instrument is available in the public domain, may be administered by non-physicians, and training is highly recommended.

Validity of the MoCA has been determined in a variety of psychometric studies, and demonstrated content validity and convergent validity with the MMSE have been determined (Nasreddine et al., 2005; Markwick, Zamboni, & de Jager, 2012; & Stewart,

2012). The MoCA has been validated in more than 12 languages (Nasreddine, 2005)). The MoCA has been compared with the MMSE for sensitivity and specificity in several studies (Ismail et al., 2010; Koski, Xie, & Konsztowicz, 2011; Markwick et al., 2012; Nasreddine et al., 2005; Stewart et al., 2012) with the MoCA outperforming the MMSE in detecting MCI (sensitivity 0.90 and specificity 0.80) using a cut-off score of 26 for cognitive impairment (Nasreddine et al., 2005). Both Stewart et al. (2012) and Markwick et al. (2012) noted that participants who tested within normal ranges on the MMSE had deficits identified by the MoCA. Internal consistency reliability has been established (Cronbach's $\alpha=0.83$) as well as test-retest reliability in sample at 35 days apart ($r=0.92$, $p<0.001$; Nasreddine et al., 2005).

The MoCA can be used free of charge. If patients are concerned about cognitive decline but have no functional problems, the MoCA would be a good choice, as it better discriminates normal cognition from MCI. However, the MoCA would be difficult to fit into the AWW due to the length of the screen and the need for professional interpretation of the scores. Additionally, Ismail et al. (2010) and Cordell et al. (2013) suggest that in patients who already demonstrate or complain of cognitive problems and functional decline, the MMSE may be a more appropriate screen.

The MoCA may be less reliable in a community population than in clinical samples (Bernstein et al., 2011) because those in a community setting may be of a more diverse background. Bernstein suggests that there has not been enough evidence to validate the MoCA outside the original study conducted by Nasreddine et al. (2005) and so this underscores the importance of validating the MoCA in other the populations.

According to the MoCA website, training and certification will be required, although no date for this decision has been posted (2016).

Knowing When to Screen

Operationalizing a brief cognitive screen in the AWW includes the choice of screen. The first step in choice of screen is indication that there may be a cognitive problem. The prevalence of cognitive impairment increases with age, so providers could consider screening for all clients older than 75 (Cullen et al., 2007) or 80 years of age, for example (NIA, 2014). An evaluation of risk factors for cognitive impairment could be considered when deciding to screen.

Cordell et al. (2013) suggest the provider use standardized evaluation questions suitable for community residents from the Behavioral Risk Factor Surveillance System (BRFSS) along with observation of the provider and informant, if available (Centers for Disease Control and Prevention [CDC], 2014). The questions ask whether patients have experienced any confusion or memory loss, need assistance with ADLs, or are having difficulty taking their medications over a period of time. The GSA workgroup suggests that patients with diabetes, depressive symptoms, and a history of falls or gait disorders may be at a higher risk for cognitive problems (2015).

A cognitive screen is not required in the AWW if there is no indication of cognitive problems. If any portion of the evaluation indicated a cognitive problem, it would be helpful for an informant to confirm or deny these indications.

Discussion

Choosing a Brief Cognitive Screen

The assessments discussed in this paper have been chosen for their practicality, availability, acceptance by providers and patients, and their psychometric properties. With the exception of the MMSE, the screens are free of charge. If cognitive complaints or observations indicate that further assessment is needed, any of the brief cognitive screens reviewed could be chosen to supplement the AWW. The decision of a screen could be decided upon provider preference whether or not there is an informant present or there is capability to perform the clock drawing.

If any portion of the evaluation indicates a cognitive problem, it would be helpful for an informant to confirm or deny these indications (Cordell et al., 2013). When an informant is available, the choice of brief cognitive screen could include the GPCOG and the AD8. These two informant and patient assessments screened well when compared with the MMSE (Brodaty, Low, Gibson, & Burns, 2006; Galvin et al., 2013) and can be administered at the time of the AWW. Informant screens may also be helpful when patients have low educational levels (Yokomizo et al., 2014).

Some patients may already have a diagnosis of MCI or dementia at the time of the AWW or a list of risk factors that could point to cognitive impairment. This is particularly relevant for residents in Assisted Living Facilities (Zimmerman et al., 2014). While ALFs may choose the MMSE or the Minimum Data Set Cog (MDSCog), researchers note there are no uniform standards in ALF facilities for the detection of cognitive problems (Magsi & Malloy, 2005). The use of a brief screen at the scheduled or unscheduled primary care provider visit could be used to detect cognitive problems or monitor any changes in condition, requiring a reassessment of cognition or a change in approach to care (Cordell et al., 2013).

Providing Follow-Up for Any Indication of Cognitive Impairment

A brief cognitive screen is meant to complement a full neuropsychological assessment when warranted (Cordell et al., 2013; Cotter, Clark, & Karlawish, 2003). The primary care provider would take the next steps to identify the cause of cognitive impairment, which could include medication side effects, metabolic disturbances, delirium, or depression. Follow-up may be challenging in primary care with the burden of extra time for testing and counseling patients and concerns about stigmatizing or labeling a patient with cognitive impairment. Only about one-half of patients who fail a cognitive screen proceed to a full evaluation (Cordell et al., 2013). A full evaluation may be problematic in regions where provider services such as geriatricians and neurologists may not be easily accessible.

Implementing Brief Cognitive Screens

Nurses, nurse practitioners, and other APRNs are important partners with families and other providers in referring for a full dementia evaluation when indicated, monitoring medications and patient progress, and determining appropriate placements at levels of care such as assisted living settings. There is opportunity to improve the detection of cognitive impairment and referral for resources, given that the AWW is a Medicare benefit for all older Americans, including those who live in AL facilities with high prevalence for cognitive impairment (Zimmerman et al., 2007). If cognitive impairment remains hidden, community-based supports, education, and caregiver resources remain unused for patients and caregivers.

The GSA workgroup suggests a four-step process to address the detection of cognitive impairment in the AWW that may be useful for the provider (GSA, 2015, p. 9):

Step 1: **K**ickstart the cognition conversation;

Step 2: **A**ssess if symptomatic;

Step 3: **E**valuate with full diagnostic; and

Step 4: **R**efer to community resources and clinical trials, depending on the diagnosis.

Steps 1 & 2 encourage the provider to begin the conversation with patients and their families about memory issues that may be surfacing. In addition to memory problems that are uncovered, the provider should be aware of other risk factors mentioned (fall risk, medication side-effects, depression). The use of a brief cognitive screen is included as part of assessment. Primary provider groups could either utilize the algorithm designed by Cordell et al. (2013) to guide a provider through the choice of a brief screen or design one as a practice group.

The third step, a full cognitive evaluation, requires processes in place for a diagnostic workup. As discussed, the primary provider group must work together to have these processes in place so that resources and community supports may be initiated. The early diagnosis of cognitive problems allows the patient and family to have conversations about what is important for future care and advance directives and to plan for legal and financial matters. “Kickstarting” the conversation could result in avoiding crisis situations later and may result in improved health outcomes (GSA, 2015).

Conclusion

This paper utilized the findings of the MDCIW and the GSA workgroup results to review brief cognitive screens that NPs and APRNs could use in the AWW or other appointments, which should include assessment of residents of assisted living facilities.

The assessment of cognitive status can provide a structured method for screening for cognitive decline at the present and over time. Assessment for cognitive decline requires observation by the provider, consideration of patient complaints and concerns from family members and caregivers (Borson et al., 2013), questions about functional capabilities, and the use of a brief cognitive screen. The cognitive screens presented are readily available, feasible, and cost effective, and may assist the primary provider in determining the need for further screening and provision of counseling, supports, and resources for patients and caregivers.

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Table 1

Characteristics of Screening Instruments

Instrument	Administration time	Total Score	Number of items	Components
MMSE	10 minutes	0-30	11	orientation, registration, short-term memory, attention, calculation and visuospatial skills
GPCOG Interview Patient	<5 minutes for patient	9	5	Orientation, memory, language, visuospatial, executive function, and other daily living functions, includes clock drawing
GPCOG Interview Informant	, 1-2 minutes for informant	6	6	Memory, orientation, judgment, and function Strictly interview
MIS Interview	<5 minutes	0-8	1=recall of 4 words	Memory
MiniCog Paper/ pencil	<5 minutes	0-5	2= recall of three words and the CDT	Memory, visuospatial, and executive function, includes clock drawing
AD8 Patient and/or informant interview	3-4 minutes for patient, 3-4 minutes for the informant	0-8 for the patient 0-8 for the informant	8	Memory, orientation, judgment, and function. Uses the same interview for both patient and informant
MoCA Interview Paper/pencil	10 minutes	0-30 points	18	Six subscales measure orientation, memory, language, attention, and executive function

Abbreviations: MMSE, Mini Mental State Examination (Folstein et al, 1975); GPCOG, General Practitioner Assessment of Cognition (Brodaty et al, 2002); MIS, Memory Impairment Screen (Buschke et al, 1999); MiniCog (Borson et al, 2000); AD8, “Eight-item Interview to Differentiate Aging and Dementia” (Galvin et al, 2005); ; MoCA, Montreal Cognitive Assessment (Nasreddine et al, 1996).

Table 2

Psychometric Properties of Screening Instruments

Instrument	Reliability	Validity	Sensitivity	Specificity	Utility	Limitations
MMSE	Test-retest reliability ranged from 0.85-0.90 for 24 hours to 0.32 for 16 months (McDowell, 2011) Folstein reported – test-retest had not fallen below 0.89 Inter-rater reliability did not fall below 0.82 (1975)	Widely used since 1975, Validated against the Wechsler Scale Available in multiple languages	pooled sensitivity of 88.3 (81.3-92.9) (Lin et al, 2013)	pooled specificity of 86.2 (81.8-89.7) (Lin et al, 2013)	Used as a reference for brief cognitive assessment Better for identifying moderate dementia than mild cognitive impairment (MCI) Considered the “Gold Standard”, cited over 13.000 times in the literature. Best value of MMSE was for ruling out dementia where negative predictive values were 98.5% and 95.7%, respectively (Ismael et al, 2009)	Proprietary- must be purchased from www.parinc.com Ceiling effect means that MCI may be missed in higher education levels. May not discriminate normal cognitive function from MCI. Educational and cultural biases. 10 minute administration
GPCOG Patient interview (Brodaty et al, 2002)	Interrater intraclass ICC-.75 Test-retest ICC 0.87 Internal consistency Cronbach’s α = 0.84	Valid in multiple languages, and in primary care settings	0.82 at cut-off of 7-8	0.70 at cut-off of 7-8	Requires an informant if the patient does not pass the initial screen Informant only has lower sensitivity (Cordell et al ,2013)	Requires an informant if the patient does not pass the initial screen Informant only has lower specificity (Cordell et al ,2013) Mixed review as to whether GPCOG is free of educational bias (Lorenz et al ,2002)

GPCOG Informant interview (Brodaty et al, 2002)	ICC=0.56, Test retest ICC 0.84 Internal consistency Cronbach's α =0.80	Valid in multiple languages, and in primary care settings	0.89 at cutpoint of 4/5 (Brodaty et al, 2002)	0.66 at cutpoint of 4/5 (Brodaty et al, 2002)	Developed and used in primary care. Good choice for patients who have a caregiver Website: www.gpcog.com.au Recommended as most suited for use in the AWV by the Alzheimer's workgroup (Cordell et al, 2012)	Requires an informant if the patient does not pass the initial screen Informant only has lower specificity (Cordell et al, 2013) Mixed review as to whether GPCOG is free of educational bias (Lorenz et al, 2002)
GPCOG Patient & Informant interview combined (Brodaty et al, 2002)	Not reported	Valid in multiple languages, and in primary care settings	0.82 at a cutpoint of 10/11 (Brodaty et al, 2002)	0.83 at a cutpoint of 10/11 (Brodaty et al, 2002)	Developed and used in primary care. Good choice for patients who have a caregiver Website: www.gpcog.com.au Recommended as most suited for use in the AWV by the Alzheimer's workgroup (Cordell et al, 2012)	Requires an informant if the patient does not pass the initial screen Informant only has lower specificity (Cordell et al, 2013) Mixed review as to whether GPCOG is free of educational bias (Lorenz et al, 2002)
MIS	good alternate forms reliability ($r=69$) and high internal consistency/reliability (Cronbach's $\alpha=.67$) (Buschke et al,	Validated in veteran population setting, community, primary	0.80-0.86 at the cut-off score of ≤ 4 for cognitive impairment (Buschke et al, 1999;	0.97-0.99 at the cut-off score of ≤ 4 for cognitive impairment (Buschke et al, 1999; Kuslansky)	Easily administered, no writing or drawing Little or no educational bias Recommended as most suited for use in the AWV by the Alzheimer's workgroup (Cordell et al, 2012)	Does not test executive function or visuospatial skills, important in IADLS Cordell et al (2013) Sensitivity was tested as low in studies reviewed by Lin et al (2013)

	1999; Kuslansky et al, 2002).	clinics	Kuslansky)			
MiniCog	Minimal data In a Korean translation test-retest reliability over four weeks ($r = 0.85$, $P < 0.01$). In the 2000 study by Borson and colleagues, the Mini-Cog correctly identified all 92 subjects with probable Alzheimer's disease and 36 of 37 patients who had other dementias.(Borson et al, 2000)	Validated in a community dwelling sample of older adults, multiple languages (Borson et al, 2003)	0.76-0.99 (Borson, 2003)	0.89-0.93 (Borson, 2003)	Brief, easy to use and score, with similar psychometrics as the MMSE. Better sensitivity than the CDT alone (Lin et al, 2013) Recommended for use in acute care by the Harford gero "Try This" series to help with discrimination of cognitive impairment from normal cognition from either dementia or delirium. Recommended as most suited for use in the AWW by the Alzheimer's workgroup (Cordell et al, 2012)	Disagreement among researchers as to sensitivity to for MCI (Kaufer et al, 2008), modest specificity and PPV may limit the MiniCog
AD8	The AD8 demonstrated good interrater reliability and stability (weighted kappa = 0.67, (0.59 to 0.75) (Galvin et al, 2005).	Available in several languages, highly correlated with the CDR (Clinical Dementia	0.74-0.85 For the informant interview 0.59 for Participant only interview	0.86 For the informant interview 0.65 Participant only interview (Galvin et al,	Recommended to differentiate cognitively intact from dementia, and can be administered by non-physician staff prior to the AWW Performs well against the CDR and the MMSE (Dong et al, 2013) Not biased by gender, culture	Informants are not always available. The Cognitive Toolkit only includes the informant interview, because the patient interview alone is not as sensitive (Cordell et al, 2013)

		Rating) and the MMSE (Galvin et al, 2005).	(Galvin et al, 2005).	2005).	or education	
MoCA	Internal consistency reliability Cronbach's $\alpha=.83$ Test-retest reliability was collected on 26 participants tested, on average, 35 days apart. (Nasreddine et al., 2005)	Widely used in and validated in 6 languages	0.80-0.90 for MCI 1.0 for dementia At cut off score of 26 (Nasreddine et al., 2005)	75.9-0.87 of normal controls for MCI. 87% at cut off score of 26 for AD (Nasreddine et al., 2005)	Recommended as part of a full cognitive evaluation when patients do not pass a briefer screen. Good at differentiating normal cognition from MCI. Nasreddine et al, (2005) recommend that patient with no cognitive complaints receive the MoCA, but it may also be paired with items from the MMSE for patients/informants who have concerns about cognition. (Ismail et al., 2010)	Requires professional interpretation Lower cut off scores may improve specificity MoCa may be too difficult for cognitively impaired patients (Konsztowicz et al., 2011) Did not perform as well with patients with lower educational status. Website states that training will become mandatory.

Chapter Four

Assisted Living as Home: A Concept Analysis

Judith Scott, PhD(c), RN

University of San Diego Hahn School of Nursing and Health Sciences- PhD in Nursing

Student

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Assisted Living as Home: A Concept Analysis

Judith Scott, PhD(c), RN

University of San Diego Hahn School of Nursing and Health Sciences- PhD in Nursing

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Abstract

Aim: To report a concept analysis on Assisted Living (AL) as home.

Background: The number of aging older adults is rapidly increasing, and changes in health policy promote provision of support and healthcare outside of acute settings. AL residences are a growing option for those who need a supportive environment but do not need the level of care provided by a nursing home. The designation of being at home by residents of AL is important to their overall well-being.

Design: Walker and Avant's framework was used to guide this concept analysis.

Review Methods: Literature from 2009-2014 was reviewed. Thematic analysis of the concepts of home and assisted living was carried out to identify critical attributes, antecedents, and consequences in order to generate a definition.

Results: Three critical attributes are: 1) a functional living space, 2) a private living space, and 3) a social living space. Antecedents include planning and execution of the move to AL as well as factors of individual competence for adjustment to the move.

Conclusion: This concept analysis clarifies how older adults may consider their residence as home in an AL setting. In keeping with the philosophy of assisted living and CMS regulations, nurses, staff, and administration need to understand and support the residents' definition of being at home in assisted living. By doing so, the provision of respectful, individualized care maximizes functional status, fosters choice and independence, and minimizes intrusions into the home.

SUMMARY STATEMENTS

Why is this review needed?

- Older adults may resist or be fearful of the idea of moving to assisted living, as the move may unintentionally give the impression that they have failed and are no longer independent, or that the move is a step toward the nursing home.
- When the concept of assisted living as home is better defined, person-centered care will incorporate a better understanding of what individual factors make a home for the resident, resulting in the resident's improved acceptance and designation of the AL as home.
- Nurses engage in concept analysis of assisted living as home to generate a definition that facilitates understanding of the concept to improve nursing practice and inform researchers, assisted living administrators and owners, and health policy makers.

What are the key findings?

- Attributes of the concept of *at home in assisted living* include AL as a functional space, a private space, and a social space. Antecedents include the older adult's planning and executing the move to AL, the adjustment phase, and the individual characteristics of the individual in accepting the AL residence as home
- Consequences include expressions of control, engagement in the activities of the AL, and the maintenance and establishment of meaningful relationships

How should the findings be used to influence policy/practice/research/education?

- Understanding what home means to older adults in assisted living settings is the first step for planning and implementing restorative care that supports aging in place principles.
- Regulations should ensure that the AL facility educates staff to maintain boundaries, sustain meaningful relationships, and assist older adults to find meaningful activities while honoring individual routines.
- Age-supportive design of assisted living facilities may further improve a home-like atmosphere while supporting independent self-care, to minimize the fear older adults have of moving to higher levels of care

KEYWORDS

concept analysis, Assisted Living, Home, choice, control, aging in place

Introduction

Nurses work with older adults in all settings, with complex medical, psychological and social contexts. Nurses have experienced being part of the disappointment when an older adult cannot return home as a result of an acute health event, decline in overall function, or for cognitive impairment threatening safety. Many older adults have been able to remain at home in their later years with support from family or hired caregivers, but when the community home can no longer meet their needs, some older adults consider a move to the Assisted Living (AL) setting. Mollica, Houser, and Ujvari (2010) report a dramatic increase in AL beds over the past few years, with this expansion accounting for a reduction of nursing home use.

Background

According to the AARP Policy Institute, states may use different terms for residential settings: board and care, assisted living, rest homes, community-based facilities, and adult foster care. Residents are 70% female, and greater than one-half are older than 85. Greater than 50% receive assistance with ADLs, and 42% of residents have cognitive impairment, including Alzheimer's disease (Mollica et al., 2010).

The National Center for Assisted Living describes AL facilities as "services designed to minimize the need to relocate...maximize residents' dignity, autonomy, privacy, independence, choice and safety..." (Mollica et al., 2010, p. 2). The level of service provided can vary among facilities, but provision of communal meals and assistance with ADLs, mobility, medications, and transportation is generally available (Hawes & Phillips, 2007).

In the US, oversight of AL settings occurs primarily at the state level. The Centers for Medicare and Medicaid Services (CMS) mandated regulations for AL settings that would be required for reimbursement: a) residents must have a lease, b) there is privacy provided with an individual room or apartment with a bathroom, 3) there is a lockable entrance, 4) aging in place must be a common practice, and 5) guests and family are free to visit any time (Mollica et al., 2010).

Older adults place great importance on their homes. Home is the center of daily life filled with memories and meaning, and older adults have a great desire to remain at home even in the face of increasing frailty. However, many understand that circumstances beyond their control may force them to leave their homes should they be unable to maintain daily self-care and residence upkeep (Gillsjö, Shwartz-Barcott, & von Post, 2011). The Western notion of independence in aging hinges on the ability of the older person to manage both day-to-day living skills and personal health activities (Becker, 1997; Löfqvist et al., 2012); therefore, older adults may resist the idea of moving to assisted living, as the idea may unintentionally give the impression that they are no longer independent.

When an older adult moves to assisted living, it is not usually anticipated with the same excitement that one might feel in buying a new house. This is in part because the older adult may feel this is not a permanent move or worse, that it is a step toward the nursing home or death. However, some older adults are able to adapt and refer to their residence in assisted living as “home.” Satisfaction with the move and the perception that one is “at home” are good signs of adjustment to an AL setting (Cutchin, Owen, & Chang, 2003).

Regulators, owners, staff, and others may have another picture of what *home* means to AL residents. For the regulator, legal protections such as leases and the presence of locked doors is required for a residence to be a home. For the owner of an AL facility, keeping a resident comfortably at home is limited by the number and type of staff who can provide needed services (Eckert et al., 2009). Caregivers who provide ADLs and housekeeping for residents may facilitate or hinder the concept of *home* for the resident by their presence and actions in the residence, which could take a brief or extended amount of time each day.

Nurses, social workers, and administrators in assisted living are tasked to design health promotion programs to slow functional and cognitive decline and prevent illness while helping residents maintain their independence and privacy and supporting their freedom of choice as much as possible. How can nurses and allied health providers best support older adults who transition into assisted living and facilitate their consideration of assisted living as home?

The purpose of this analysis is to clarify the most important attributes of assisted living as home, clarify antecedents and consequences, and generate a definition for clinical practice, research, and health policy. This analysis should provide an understanding of assisted living as home that offers insight into how to provide appropriate levels of care while maintaining dignity, autonomy, and individual choice.

Data Sources and Processes

A literature search was performed to find as many meanings of the concept as possible. Databases searched were CINAHL, PubMed, and Google Scholar. Search terms applied to the review were *assisted living*, *becoming at home*, and *residential care*.

The search terms were combined with *older adult*, *autonomy*, and *independence*. The search yielded 209 studies published between 2009 and 2014, which was further refined by searching the reference lists of selected articles. Studies were limited to peer-reviewed and full-text articles. The words *home*, *assisted*, and *assisted living* were examined separately and together from dictionary, thesaurus, and varied literature resources that older adults and professionals would consult for definitions of assisted living. Uses of the concept were explored to perform an analysis of the concept as defined by Walker and Avant (2011). The clinical experiences of the researcher with older adults in residential retirement communities were used to build the case exemplars.

Results

Uses of the Concept

Home

According to Walker and Avant (2011), it is important to find as many uses of the concept as possible to provide the basis for defining attributes. The discussion of the concept of assisted living as home begins with the definition of each term. *Home*, when used as a noun, defines a place where a person lives, a dwelling place (Merriam-Webster Online, 2015b). *Home* also can mean a starting place in a website or a location at the center of a larger entity. *Home* is used as the object of a verb when referring to locating or placing an object or a company; baseball players, for instance, run home in the game. Being *at home* is a very familiar use of the concept of being comfortable with a topic or a place. For the purpose of this discussion, *home* as a noun is broken down into physical home, heavenly home, and emotional home.

Physical home

Home can mean the place of one's birth, a childhood or family home, or the town, community, or country where one resides (Gillsjö et al., 2011). Home is a physical place where people live their daily routines. People who are homeless are without the very basics of home: a place to prepare food, perform hygiene, and tend to their personal care needs or a place with locked doors that represents safety and shelter (Parsell, 2010). Fundamental to home as a physical space is privacy, autonomy, and freedom to choose one's social circle and activities. When health care is required within the home in AL others enter to provide assistance, and this may affect the dynamic in the home and the sense of being at home (Gillsjö et al., 2011).

Heavenly home

Not all older adults hold a formal religious belief system; however, many may express their attachment to a heavenly place or home. A strong faith in God may offer feelings of security in life that are helpful in adapting to the assisted living setting. The final home is heaven, considered better than on earth. One resident described that her faith improved her adjustment to assisted living because she knew her heavenly home was waiting for her (Gillsjö et al., 2011).

Emotional attachment: Home is where the heart is

Home is a special relationship, an emotional sense of belonging. Home provides a link to one's identity, personal values, cultural norms, and beliefs (Molony, 2010). This relationship to one's home is characterized by songs like "I'll Be Home for Christmas" (Gannon & Kent, 1943). Being away from home can produce the experience of homesickness that may disturb well-being (Gillsjö et al., 2011; Parsell, 2012). Older

adults who have moved into AL may have already experienced homesickness for their family or childhood homes but experience it anew when confronted with a new downsized residence, a new social circle, and new caregivers.

Social home: Family and friends

When AL residence becomes necessary, there is a risk that older adults may be displaced from their social circles. Residents may have limited transportation to visit or receive visitors, including neighbors, family members, and familiar service providers. Having a higher proportion of family ties in residents' circles has been associated with improved well-being. Residents fear the loss of relationships, which may add to the resistance of moving. While in theory visitors may come and go at any time, AL facilities have differing policies about guests signing in and out or signing a waiver of risk in some cases, which can make visitation challenging (Bennett et al., 2015).

Furthermore, receiving health care in the home often changes the dynamic of social exchange and may result in new bonds between the caregiver and the resident, which can displace older relationships with family members (Gillsjö et al., 2011). Adjustment to the AL includes negotiating both old and new networks of association, and the ability of the residents to do so depends in part on their personality and the presence of family or friends, who may facilitate this process (Bennett et al., 2015).

Assisted & living

Assisted, when considered apart from the word *living*, is thought of as an adjective and means having or receiving help, being aided, or making a situation easier for another person (Merriam-Webster Online, 2015a). The pairing of *assisted* and *living* results in improved ability of resident to perform ADLs, manage communal meals, and receive

their medications, which may have not been previously possible. Synonyms for *living* include *functioning*, *running*, and *working* (Merriam-Webster Online, 2015c). Assisted living is designed to provide assistance with activities of daily living while promoting as much independence as possible. The Assisted Living Foundation of America (ALFA) defines assisted living “as a long-term care option that combines housing, support services, and health care, as needed” (2016).

Identification of Defining Attributes

The defining attributes of a concept are the critical characteristics that help to differentiate one concept from another and clarify its meaning (Walker & Avant, 2011). A review of the relevant literature integral to the concept of *assisted living as home* returned three defining attributes. AL must be: 1) a functional living space, 2) a private living space, and 3) a social living space.

A Functional Living Space

Residents in assisted living need physical support from staff in terms of housekeeping, ADLs, and medications. The AL apartment or room is an individual space with a private bath and often a kitchenette. Accessible features are built in to address functional and safety needs. What makes this living space home-like is, in some cases, the design of the building and the customization the apartment or room with items that belong to the resident. Personal belongings, even though they may be fewer than the resident’s previous dwelling (such as photographs), may elicit fond memories, create emotional attachment, and reinforce identity for the resident (Hersch, Spencer, & Kapoor (2003).

A private space

Home is a safe haven, a place where the door may be closed and a boundary set apart from the rest of the facility. Health care providers and staff knock upon entering to respect the privacy of the space. Doors are locked at night, if residents so choose. When residents prefer to not attend a communal meal or an activity, it may be a time to withdraw to a place of safety, comfort, and personal ownership (Molony, 2010). The residents feel they may come and go when they please; however, they need to sign out of the facility and are accounted for when they miss meals. This supervision may be a challenge for AL residents who consider the privacy of their apartments sacred and their plans for the day as their own (Eckert et al., 2009).

A social space

Research evidence indicates that social relationships are essential for healthy transition (Schlossberg, 1981). Home is a center of daily life, and friends and family are welcomed inside. Staff may also become part of the inner circle of relationships when they promote health and well-being of older adults in their AL residence (Moloney, 2010). In addition to having a home where family and friends are welcome, the assisted living facility may provide opportunity for new relationships in communal spaces, which may improve the sense of being at home in the new setting (Street & Burge, 2012). If residents with mild cognitive deficits are also housed in assisted living, AL residents may not be happy to interact with others who may not be able to communicate well (Tracy & DeYoung, 2004).

Construction of a model case: Model and additional cases

A model, a borderline, and a contrary case will be presented from the researcher's previous clinical experiences working with older adults in acute AL and long term care. The model case should provide all the defining attributes of the concept so that the reader can clearly understand what *assisted living at home* should be (Walker & Avant, 2011).

Model Case

Residing in an assisted living setting may not be interpreted by the older adult as *at home*. The purpose of the hypothetical case is to provide an exemplar of being at home in assisted living and includes all the defining attributes: AL as a functional space, a private space, and a social space.

A retired couple live in a condominium not far from their children. The family visits, and the couple enjoys the sharing social life with family, friends, and neighbors. Over time, the older woman becomes widowed. Recovery from a fall leaves her unable to cook, keep house, or shower independently. With support of her family, she makes an appointment at the local assisted living and puts her name on the waitlist. In concert with family and health care providers, the decision is made to move to AL. Staff assists her with medication and activities of daily living, and she attends group meals. Privacy is assured by a locked door, and safety is promoted with an appropriately designed bathroom arrangement and safety pull-cords. Her family and friends visit in the new home, a smaller apartment furnished with her furniture and treasures. The older woman begins to explore the activities offered and accepts opportunities to meet her new neighbors, inviting them in to visit. As she physically improves, she no longer needs assistance with her medications but asks for supervision with showers. Eventually, she is

able to fix her morning toast and coffee but does not use the stove or oven for cooking.

After a year passes, the resident calls the assisted living apartment *home* and says, “This is where I want to stay the rest of my life.”

The assisted living meets the requirements for the defining attributes of an assisted living, including privacy, safety, and social needs. The apartment is leased to the resident and care is offered as needed. Furthermore, the resident is able to entertain and to call the apartment *home* after a year. She demonstrates healthy adjustment when she calls the new space *home* and her overall health and independence are improved.

Borderline case

The borderline case is one that contains most but not all the defining attributes of assisted living at home (Walker & Avant, 2011). The following exemplar is very close to the concept of being at home in AL but lacks the social space requirement to demonstrate integration into the community.

An older widow has moved into assisted living, as she has physical impairments that require her to use a walker and vision and hearing impairments that have affected her ability to read and require her to stop cooking for safety reasons. Her family lives in another state, so she felt that assisted living was the best choice. Her apartment is decorated with items from her community home, including several pieces of art she created. Staff come to her apartment and make sure that her ADLs are supervised and that she gets her medications. She attends communal meals and goes to exercise classes twice a day. However, she complains of loneliness and isolation because she cannot hear to converse with her tablemates at meals and since she cannot see, she states that she often does not know who is speaking to her, which makes her feel lonely. She expresses

gratitude for her apartment and the care that she receives but does not feel the assisted living is her home.

The assisted living meets the requirements for the defining attributes of an assisted living with the exception of a social space. The space is functional, reflects her taste, and contains her possessions; however, this woman has not been able to connect to other residents at meals and in common spaces because of her sensory impairments, and thus she expresses isolation and does not consider her AL apartment home.

Related case

Walker and Avant (2011) state that related cases are similar to the concepts being studied but do not contain all the defining attributes. Describing related cases can be helpful in seeing how the concepts fit in with other close concepts. This exemplar of a related case illustrates both the concepts of assisted living and being at home, but the place is not an assisted living facility.

An older woman has recovered from a fractured hip and moved in with her daughter at her daughter's request. The daughter's home has a "granny flat" that includes a kitchenette, separate bath, and living area from the main home. The daughter offers meals when needed and manages errands with her mother, since her mother no longer drives. Her mother is able to attend church and the senior center when her daughter can drive, but there is also a senior transportation service that helps. While her mother misses her house, she states that she is content living at her daughter's house and calls it home.

In this exemplar, the home is attached to the daughter's home and provides a functional place for ADLs, privacy, and social interaction. The mother calls it home. While this is a very satisfactory arrangement, there is the possibility that the daughter will

not always be able to care for her mother this way, which may lead to a residential placement.

Contrary case

The purpose of the contrary case is to illustrate what assisted living at home is not. Walker and Avant (2011) suggested the contrary case must not include any of the defining characteristics of the concept in question. While a hospital meets the concept of home as a place, even though it is functional space, it is not acceptable to the patient as home and does not provide privacy or a social space.

An older woman has endured a disabling stroke and is unable to feed, bathe, or dress herself. Aphasia has rendered her speech unintelligible. Since she has no family, she is currently in an acute care facility, waiting for a transfer to a nursing home. She cries often and the staff has been unable to communicate with her.

This exemplar defines the very challenging scenario: life with a stroke in limbo between acute care and a nursing home, separated from loved ones and unable to speak and make needs known. Creating a home for this patient in the nursing home is outside the scope of this discussion and would be very challenging. The living situation in acute care with transition to a nursing facility does not meet the requirements for the defining attributes of an assisted living. Providing privacy, safety, and social needs in a homelike atmosphere may be possible over time; however, older adult may not be able to verbalize any sense of being at home.

Antecedents

Antecedents are the circumstances that precede the concept being studied (Walker & Avant, 2011). *Assisted living as home* is preceded by four factors: 1) the move to AL,

2) the adjustment to AL, 3) the individual competence of the resident, and 4) the length of time living in the facility. First, the older adult or family members may plan and execute the move to AL with some or no degree of participation or as a response to a health crisis (Johnson & Bibbo, 2014). When this transition is a planned move, the resident may be familiar with the assisted living facility, which is helpful in perceiving the move in a more optimistic light (Meleis et al., 2000).

There is an adjustment phase when residents are settling into the AL. Becoming comfortable in the new setting is an adaptive process of maintaining control of the overall move, perceiving the move as positive, retaining social and family ties, establishing relationships and activities, and discovering that the new environment is balanced in terms of tangible and intangible resources (Perry, Anderson & Kaplan, 2013; Schlossberg, 1981). Tangible resources include items from home to decorate the new space, continued connections with family, and the maintenance and establishment of social resources like staff relationships or tablemates at meals. Intangible resources include positive perceptions of the move, a healthy perspective of the home left behind, and the establishment of a sense of belonging in the AL.

Individual characteristics affect the ability of residents to adopt the new residence as home (Perry et al., 2013). Residents who are grieving the loss of a spouse or have physical, sensory, or cognitive losses may be more challenged to adapt to assisted living and need extra care and support. Some AL residences may have memory care units to improve the experience of residents with cognitive impairments.

Finally, the length of time that a resident spends in AL is significant in becoming established in the residence, as it may foster connectedness to the place. It may be

counterproductive to name a particular span of time that might represent adjustment, since transitions are individual and ongoing (Meleis et al, 2000); however, it is clear that aging in place principles call for maintaining a resident in AL as long as possible to foster the sense of belonging and prevent another disruption and move (Cutchin, Owen, & Chang, 2003).

Consequences

Consequences are the end results or outcomes of the concept being studied (Walker & Avant, 2011). The literature indicates that expressions of control, engagement in activities of the AL, and the establishment of meaningful relationships are outcomes of being at home in assisted living.

Expressions of control

When a resident moves to AL, becoming at home in the new setting is an adaptive process of maintaining control. At home, the space is decorated with significant belongings, no one can enter without permission, the approach to the day's schedule is decided by the resident, and ADLs are resident-directed and support the older adults' needs (Gillsjö et al., 2011). When residents express maintaining control of their lives, also referred to as *mastery zones* (Golant, 2011), they experience personal growth and an improved sense of meaning. Older adults acknowledge possible limits on their physical or psychological health that could threaten their ability to stay at home.

Engagement in activities of the AL

Residents who make their residence a home begin to develop a menu of meaningful activities for community engagement (Saunders & Heliker, 2008). The activities need not be the traditional exercise or Bingo; residents may find enjoyment in

working on jigsaw puzzles, attending bible studies, or participating in resident council meetings. Residents find a balance of engagement and privacy that suits their personality and their social needs. Satisfaction with the range of activities offered by the AL indicates a good fit for the resident and may help build friendships and improve quality of life (Cutchin, Marshall, & Aldrich, 2010).

Meaningful relationships

Participants who described the staff positively and who were able to find friends at mealtimes expressed contentedness and adjustment. “Joining the family” is a predictor of health and adjustment (Street & Burge, 2012; Ferrand, Martinent & Durmaz, 2016). Bonding between residents in assisted living was improved when staff made an effort to connect people with similar interests through card games, crafts, reading groups, and opportunities to participate in self-governance (Tracy & DeYoung, 2004).

Sustaining friendships and family ties is important to resident satisfaction, whether by email, phone, or in person. Family caregivers may facilitate new relationships internally and assist residents in maintaining ties to their previous lives, which can optimize adjustment (Street & Burge, 2012).

Determination of Empirical Referents

According to Walker and Avant, empirical referents are the means by which the defining attributes are recognized and can be measured (2011). Empirical referents can be both subjective and objective. Calling assisted living *home* is an example of a subjective empirical referent for purposed of this analysis. Measurement of satisfaction with assisted living as home could be also be expressed by residents’ desire to live out the remainder of their lives in the AL, as do persons who love their homes (Gillsjö et al.,

2011). Malony's (2010) qualitative metasynthesis of the meaning of *home* combined the results of 23 studies to distill overarching metaphors for the term. Supporting the essential attributes of the current concept analysis, *home* was described as the place of refuge (private space) and empowerment where the resident can do as he or she pleases (functional space), and a place where there are relationships (social space).

There are several quantitative instruments identified that assess environmental satisfaction using Quality of Life (QOL) measures, but most of them assess "at homeness" by indirect ratings of satisfaction in multiple domains (Molony, McDonald & Palmisano-Mills, 2007). The Experience of Home (EOH) scale was developed as a direct measure of "person-environment transaction" to capture the experience of being at home (Molony et al., 2007, p. 519) and measured the experience of home, QOL, and housing satisfaction. The investigators administered this 25-item instrument to both community and long-term residents, including AL residents. Questions about feeling at home (private space, social space), feeling cared for (social space), having a place of one's own (private space), and feeling free to make choices (functional, private space) reflected the critical attributes of the concept of home. Principle components analysis provided support for construct validity and internal consistency reliability was supported with a Cronbach's alpha of .96 for the entire scale. Length of time in the long-term setting improved the EOH scale in the long-term settings (Molony et al., 2007). This instrument could be administered in intervals to note changes in residents' perceptions or to test interventions that may strengthen resident connections to their space.

Discussion

Overall summary

In their structural analysis of factors indicating “at homeness” in assisted living Cutchin et al. concluded that while an inexact designation, it is important that older adults call their residence *home* (2003). Adjustment indicates there is growth with this change rather than decline (Schlossberg, 1981), possible improvements in health status, evidence of meaningful relationships, expressions of control, and engagement in the activities of the assisted living facility (Cutchin et al., 2003). While some residents may mention a preference for a heavenly home or that the new home is not the same as the family or childhood home, they express satisfaction with their residence as home (Gillsjö & Schwartz-Barcott, 2010).

The length of time it may take for a resident to adjust is variable, just as each person’s interactions with any new situation differ with the individual. Length of residence was correlated with the Experience of Home (EOH) study in assisted living facilities (Molony et al., 2007). Differences in the amount of perceived control and the establishment of activities and relationships can affect the timeline as well as physical or cognitive frailty.

Exploration of the concept of assisted living as home guides the reader to systematically understand how an older adult moving to assisted living may, over time, find the new space to be a home. Ideally, residents bring memories from their childhood home and their community home such as photographs, art, and specific pieces of furniture to bring comfort and familiarity to the new space. Privacy is negotiated by the unlocked door during the day, with a knock to enter by staff. Adjustment includes the balance of negotiating the flow of the day at the AL with the personal agenda of the

residence. Staff strives to provide assistance without intrusion. Since assisted living facilities vary widely in physical appearance and may serve residents from different cultural and socioeconomic backgrounds, it is important to look for the defining attributes of assisted living as home as an outcome of adjustment.

Nursing implications

Nursing practice is informed by transition theory (Meleis et al., 2000). The response to transition into the AL residence provides an opportunity for nurses and health care providers to facilitate this adjustment at many points. When older adults are discharged from acute care, proper counsel and direction from transition coordinators can examine the individual and family resources and support of the older adult to strategize the selection of a facility with an appropriate fit. Nurses can lessen the anxiety and loss of a residential move by coordinating visits from staff, volunteers, family, and friends, and provide a listening ear frequently during early phases of the transition. A spiritual assessment should not be overlooked to determine what practices and needs are present (Warring & Krieger-Blake, 2006).

Nurses are key to educating facility staff to understand the concept of being at home in AL so that all staff may facilitate the establishment of meaningful relationships, sustain family ties through support of celebrations and rituals, and establish flexible boundaries that support privacy and social needs. When AL becomes home, resident health can be improved when the space fosters autonomy and facilitates engagement and attachment.

Nurses partner with all care providers to identify residents who are not adjusting well in the transition to AL. Individual competence affects the ability of residents to

adopt the new residence as home (Perry et al., 2013). Residents who experience a sudden move or had little or no choice in the move or who are physically frail, grieving the loss of a spouse, or have sensory or cognitive losses are more at risk for poor adjustment. They may be more challenged to adapt to assisted living and need extra care and support. While some assisted living residences may have memory care units to improve the experience of residents with cognitive impairments, the majority do not, so nurses need to be cognizant of those residents and provide extra resources for their care and comfort.

Limitations

The purpose of the concept analysis was to operationalize the definition of being at home in assisted living and cannot be generalized to other populations. The literature search excluded studies that were non-English and generally represented the Western idea of a linear life trajectory as characterized by Becker (1997). An expanded definition of older adult from non-Western countries would likely alter the definition of being at home in assisted living.

Conclusions

The purpose of this analysis is to clarify the most important attributes of assisted living as home. Transitions from one living situation to another are difficult for older adults. While adjustment is individual, processes of becoming at home have defining attributes that can provide cues to how well the new resident is settling in. Further research specific to assisted living is needed to develop instruments and assessments that reflect at homeness in AL. Further exploration of being at home in assisted living is needed from an inter-professional perspective, as perceptions of being at home in AL may vary among other care providers.

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Chapter Five

Discussion of Findings

Judith Scott, PhD(c), RN

University of San Diego

Discussion of Findings

The purpose of this dissertation was to explore the transition process from independent living to assisted living (AL) within a planned retirement community. Perspectives were explored through a) the lived experience of older single women who actually made such a transition, b) a critique of cognitive impairment screens, and c) a concept analysis of *assisted living as home*. Chapter Five presents a synthesis of the dissertation, critique of the overall study, implications, and recommendations for future research.

Transitions to Assisted Living within a Continuing Care Retirement Community

The purpose of the dissertation study was to explore the lived experience of older single women who move from the independent home to the AL setting, both situated within a continuing care retirement community (CCRC). The opportunity to deeply reflect upon what it means to be an older woman moving to an AL setting provided insights as to how women perceived this relocation between two levels of a planned retirement community. Transitions to levels of care within CCRCs were discussed within the context of transitioning from the independent setting to assisted living, noting that many women experienced widowhood, physical aging, and encountering others with cognitive impairment simultaneously.

The exploration of the literature for this study yielded insights as to how other qualitative and quantitative researchers uncovered the experiences of older adults who transition to nursing homes or from community homes to assisted living. This exploration of sources was performed with the knowledge that it was important to explore the existing literature for findings and approaches, but not hinder or bias the

researcher in the personal experience with the transcripts. Qualitative researchers frequently practice bracketing, or setting aside preconceived ideas about the phenomenon itself (Giorgi, 1997). This study utilized a newer concept adapted by Dahlberg called *bridling* (2006). As Dahlberg was a horsewoman, it is fitting that bridling steers the research proactively away from preconceived ideas but does not limit forward motion and is described as an active process. However, the use of bridling allows an awareness of previous experience, providing a forward impetus to question and wonder about the phenomenon at hand. This researcher's findings from the literature and from personal conversations were set aside after journaling. It was this journaling that was helpful in bridling any preconceived ideas.

The findings from the interviews of 17 older women resulted in three themes: *preplanning*, *executing* the move by downsizing to the smaller apartment, and *adjusting* after the transition. Within these three themes, subthemes were identified and discussed.

Cognitive Screening

While women with cognitive impairment were not enrolled as participants in the research study, cognitive impairment among other AL residents was brought up during study interviews. According to Zimmerman, Sloan, and Reed (2014), cognitive impairment was found to threaten aging in place in both community and assisted living settings. Cognitive impairment can be found in as many as 7 in 10 AL residents; therefore, the topic of cognitive impairment screening held interest for the investigator and this interest was explored through the writing of a manuscript presented in Chapter Two. The focus of this manuscript was to provide a review of the brief cognitive screens recommended for the AWV by the Alzheimer's Association and the GSA workgroup,

discuss the incorporation of brief cognitive screens in primary care visits, and make recommendations for the use of brief cognitive screens as part of a personalized health plan. The engagement of primary care providers such nurses and nurse practitioners with residents, families, and caregivers is important for both screening and follow-through on the coordination of resources for findings of cognitive impairment; all are deemed important for adjustment into assisted living. Interestingly, participants in the study recognized the prevalence of cognitive impairment in others in the AL settings, had cared for a spouse with Alzheimer's disease, or were aware that they too could "go bonkers."

Assisted Living as Home

Using the framework by Walker and Avant (2011), the concept of *assisted living as home* was defined based upon the published supporting literature. The defining attributes of the concept are AL as 1) a functional living space, 2) a private living space, and 3) a social living space.

As a functional space, residents in AL receive physical support from staff in terms of housekeeping, ADLs and medications. The AL apartment or room is an individual space made homelike by the design of the building or customization of the space with items that belong to the resident. Personal belongings, photos and art, even though they may be fewer than the previous dwelling, may elicit fond memories and create emotional attachment and reinforce identity for the resident (Hersch, Spencer & Kapoor, 2003).

Home is a private haven, a place with a boundary from the rest of the facility. Staff knocks upon entering to respect privacy. Doors are locked at night if the resident so chooses. When a resident prefers to skip a communal meal or an activity, it may be a time to withdraw to a place of comfort and personal ownership (Molony, 2010). There is

a certain amount of supervision necessary for safety, which may be a challenge for residents who live in AL and consider the privacy of their apartments sacred and their plans for the day as their own (Eckert et al., 2009).

Home is a social space. Research evidence indicates social relationships are essential for healthy transition (Schlossberg, 1981). Home is a center of daily life, and friends and family are welcomed inside; staff may also become part of the inner circle of relationships when they promote health and well-being of older adults in their AL residence (Molony, 2010). The AL may provide opportunity for new relationships in communal spaces, which may improve the sense of assisted living as home (Street & Burge, 2012).

Exploration of the concept of *assisted living as home* guides the reader to systematically understand how an older adult moving to assisted living may, over time, find the new space to be a home. Ideally, residents bring memories from their childhood or community home, such as photographs, art, and select pieces of furniture, to bring comfort and familiarity to the new space. Privacy is negotiated by the unlocked door during the day, with a knock to enter by staff. Adjustment includes the balance of negotiating the flow of the day at the AL with the personal agenda of the resident. Since assisted living facilities vary widely in physical appearance and may serve residents from different cultural and socioeconomic backgrounds, it is important to look for the defining attributes of assisted living as home as an outcome of adjustment.

Of note, elements of the concept *assisted living as home* were revealed in the study findings. Characteristics of functional living space, private living space, and social living space were present throughout the study findings, including subthemes. For

example, the ability to adjust well into assisted living was characterized by the subtheme *the place for me*. Study participants expressed control over the planning and executing of their move, were pleased with their new apartments and the furnishings they brought, and had found new routines of the day satisfying. They negotiated social activities and communal dining well.

Of note, participants who did not designate assisted living as *home* or the *place for me* were those with sensory or physical impairments that hindered control, engagement, and the establishment of relationships. Participants with physical or sensory limitation or those who had moved because of an acute event were more challenged in adjustment. One of the participants verbalized poorer well-being and loneliness. She was missing possessions that had disappeared during her move and while making the best of what vision she had, was experiencing isolation. Because they may not be able to join in with others in volunteer or social activities, residents like this participant are at higher risk for loneliness, depression, and poor adjustment (Meleis et al., 2000) and therefore, *assisted living as home* may not be actualized for all residents.

Nursing Implications

A number of nursing implications exist based upon the study of participants' lived experiences of transition to assisted living. There are numerous roles for nurses in caring for residents in AL in terms of assessment, planning, and designing and monitoring strategies to assist older adults to transition into AL settings.

First, while nurses manage medications and other routine care, extra attention to signs of isolation or declining physical and cognitive function should alert the nurse that a new resident may be having difficulty. Vision, hearing, and cognitive impairment may

be able to be addressed by thorough assessment during routine visits, and changes should alert the nurse to contact the primary care provider for further evaluation. Nurse practitioners (NPs) and other advanced practice nurses (APRNs) in AL settings should be able to assess cognition during the patient visit through observation, asking specific questions of patients and caregivers about cognitive or functional changes, ruling out comorbid conditions that could affect cognition, and administering a brief cognitive screen if indicated. The use of an appropriate screen can be a beginning step toward further diagnostic evaluation to determine the cause and extent of cognitive impairment. Appropriate referrals for diagnostic workup may be made and support may be offered to assist patients, families, and caregivers.

Second, nurses who work in assisted living have the opportunity to develop plans of care that address those residents who are at risk for poor adjustment. While some study participants expressed being familiar with assisted living because they lived in a CCRC or had visited neighbors who had moved, others with physical or sensory limitations or who had moved because of an acute event were more challenged with their adjustment (Johnson & Bibbo, 2014). When new residents are having difficulty with integration into the AL, nurses can build frequent staff and resident meetings into the plan of care early on to facilitate communication and be certain the needs of the new residents are being met. In addition, staff education could include active listening strategies that could enhance communications between residents and staff.

Third, as a strategy to assist with integration into the AL, registered nurses can refer at-risk residents for chaplain visits, social work or therapy consultations. Saunders and Heliker (2008) suggest that interdisciplinary teams that include nurses should partner

with residents and staff to provide person-centered care. Since many AL facilities may depend on trained non-nursing staff to pass medications, NPs and nurses in supervision of AL facilities are especially important in the follow through of diagnostic workups and medication management (Zimmerman et al., 2014).

Finally, nurses who are directors of assisted living facilities, function well on interdisciplinary teams with the medical staff, administration, and owners are important advocates for AL residents. Nursing directors should ensure that physical and psychosocial assessments conducted upon admission (and at regular intervals) are completed in a timely manner and combined with a history of the resident's previous life and past patterns of managing of daily decision-making. This information can assist staff and caregivers in being intentional about personalized care (Kennedy et al., 2005). As the number of older adults in the US continues to increase, with concurrent rising acuity of residents, nurses are in a prime position to determine the extent to which older adults become integrated into AL and perceive the new environment as home.

Recommendations for Future Research

The dissertation study explored the lived experience of older women transitioning into assisted living from the IL setting of a CCRC. While this work fills the gap in understanding the experience of a group of older women in a supportive community, other gaps remain. With the rapid increase in frail older adults, AL settings will need to accommodate residents with higher acuity and an increasing presence of cognitive impairment (Zimmerman et al., 2014). This reality may threaten the ability of residents to transition well and perceive the AL as their home. Furthermore, the next wave of older adults who will be considering assisted living as an option are the Baby Boomers, who

exhibit significantly different attitudes about aging (Roth, Koenig, Rubinstein....Peeples, 2012). This new aging cohort has implications for future transition experiences and therefore nursing research should explore the unique needs of the Baby Boomer generation. Lin & Brown (2011) note that one in three Boomer women are unmarried, making them more vulnerable than those who are married and bringing a new group of single women into assisted living. In addition to vulnerability related to singleness, these older women fear age-related illness and decline (Lin & Brown, 2011; Roth et al., 2012). The transition experience of the women in this study will yield new insights that impact how assisted living settings support older adults and provide care.

The findings of this study indicated that participants with sensory impairments experienced more challenging transitions. Future research could examine factors that may improve the transition experience for these older adults. Maintaining their functional status may require unique transitioning strategies, including high tech-high touch approaches to prevent functional and cognitive decline and social isolation.

This study has raised a question about cognitive impairment among AL residents. Controversies exist over conducting cognitive screening in AL settings. Descriptive research may help identify issues related to resources, time, appropriate screening instruments and processes, and personal privacy. Future research may also be helpful in understanding how increasing levels of cognitive impairment affect important resident relationships in assisted living, the experience of assisted living as home, and quality of life.

Conclusion

Support for older adults' ability to age in place where they presently live is a national strategy as well as a philosophy (US Department of Health and Human Services, 2011). The rapidly growing number of older adults needing support in later life creates an urgent need for models of care fitted to many living situations. Assisted living is one setting offering such a model of care. The dissertation study explored the lived experience of older women transitioning from independent living to assisted living. In addition to the data-based study, a concept analysis on assisted living as home and a critique of cognitive impairment screens were conducted and all three are presented as manuscripts.

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Appendix A

Interview Guide

Participant Code Number:

Date of Interview:

Time of Interview:

Location of Interview:

Participant:

- Looking back at the time that you moved into assisted living, can you tell me about the move?
- Was this a planned move? Can you tell me about that?
- How did you feel about the experience of moving to assisted living?
- How do you feel about your assisted living situation now?
- Is there anything else you would like me to know?

Probes:

- Tell me more about this?
- What happened then?
- Can you explain this a little further?
- What happened that prompted the move?

Appendix B

USD IRB

Institutional Review Board Project Action Summary

Action Date: May 5, 2015

Note: Approval expires one year after this date.

Type: ☐ New Full Review ☒ New Expedited Review ☐ Continuation Review ☐ Exempt Review
☐ Modification

Action: ☒ Approved ☐ Approved Pending Modification ☐ Not Approved

Project Number: 2015-05-257

Researcher(s): Judy Scott Doc SON
 Dr. Ann Mayo Fac SON

Project Title: The Experience of Single Older Women Who Have Recently Transitioned to Assisted Living within a Continuing Care Retirement Community

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

Modifications Required or Reasons for Non-Approval

None

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit a project proposal for expedited review at any time.

 Dr. Thomas R. Herrinton
 Administrator, Institutional Review Board
 University of San Diego
herrinton@san Diego.edu
 5998 Alcalá Park
 San Diego, California 92110-2492

Office of the Executive Vice President and Provost
 Hughes Administration Center, Room 214
 5998 Alcalá Park, San Diego, CA 92110-2492
 Phone (619) 260-4553 • Fax (619) 260-2210 • www.sandiego.edu