

## **REDUCING RELOCATION STRESS**

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## **CHAPTER 1**

### **What is Relocation Stress?**

Many older adults move from their homes for myriad reasons. Sometimes the move is planned (such as seeking a smaller retirement home vs. family home) and sometimes unplanned (such as in response to acute illness). Whether voluntary or not, these changes are stressful. The involuntary changes are usually more traumatic. How can we, as health professionals, loved ones, and caregivers minimize the stress? The first step is obviously to learn to recognize the symptoms of relocation stress.

A relocation process typically consists of:

- 1) A decision and preparation stage prior to relocation, also known as an anticipatory stage, could include thoughts about moving, exploration of assisted living or retirement communities, financial planning for a move, packing, etc.
- 2) An impact stage within which the actual physical transfer occurs, which includes moving from one place, transferring and setting up services (such as home health, telephone, cable, change of address, etc.) to another location, and unpacking.
- 3) A settling-in or long-term adjustment stage, which includes everything from introductions to staff and other residents to mood reactions to the new environment.

Relocation Stress Syndrome (RSS) is a disturbance of physical or psychological functioning occurring as a result of transfer from one environment to another. This change of environment can be:

- 1) From home with the expectation that they will stay in the new placement,
- 2) From home with the expectation that they will return home,
- 3) From a medical surgical unit with the expectation that they will stay in the new placement,
- 4) From a medical surgical unit with the expectation that they will go home,
- 5) From Long Term Care (LTC) facility to LTC facility,
- 6) To or from a retirement community, and
- 7) To or from living with family.

RSS is remarkably similar to the psychiatric diagnosis Adjustment Disorder. Adjustment disorder is "the development of emotional or behavioral symptoms in response to an identifiable stressor" with symptoms of "marked distress and significant impairment in social or other functioning." Symptoms of depressed mood, anxiety, and/or disturbance of conduct can prevail, and in fact define different types of Adjustment Disorder. The main differences between RSS and Adjustment Disorder are

1) a person with Adjustment Disorder often has only one of these predominant symptoms, whereas those with RSS may exhibit all the types of Adjustment Disorder at the same time, and 2) a person with adjustment disorder may experience symptoms in response to any stressor, whereas RSS is specifically a response to a move. Symptoms that may occur following a change in environment or location include:

- 1) Anxiety (expressed by restlessness, fatigue, irritability, muscle tension, sleep disturbance),
- 2) Apprehension (suspicion, fear, especially fear of future evil or foreboding),
- 3) Depression (depressed mood, loss of interest in previously enjoyed activities, change in weight [usually loss], fatigue, psychomotor agitation or [usually] retardation, and feelings of worthlessness/helplessness),
- 4) Diminished ability to think or concentrate,
- 5) Indecisiveness,
- 6) Suicidal thoughts,
- 7) Increased confusion (60% experience confusion in the first 28 days following move),
- 8) Loneliness, and
- 9) Increased possibility of elopement (leaving placement without adequate care and no intent to return).

### **Why is RSS Important?**

RSS can almost double the risk of death. RSS also creates a more turbulent and unhappy environment for other residents, who may have negative reactions to one resident with RSS. RSS may result in more frequent complaints and overreaction to perceived wrongs by the older adult, which may in turn increase the risk of actual or accusations of abuse and/or neglect.

### **Who develops RSS?**

Research indicates that almost anyone can develop RSS, but may show different reactions. Reactions seem related to the relative importance of independence and autonomy to each person at the time of relocation. RSS categories include:

- 1) Resigned resisters, who experience brief episodes of withdrawal, crying, and sadness to profound expressions of hopelessness and helplessness (seen more often in women), and
- 2) Forceful resisters, who experience anger, distrust, noncompliance, and exhibit aggressiveness and physical/verbal abuse to staff (seen more often in men).

## **CHAPTER 2**

### **Major Stressors**

Rankings of potential stressors rate the difficulty level of change of residence and change of job as second only to divorce or death of a spouse. Factors related to the development of RSS include:

- 1) Past, concurrent, and recent losses (such as the death of a spouse or significant other),
- 2) Losses involved with the decision to move (including loss of independence, choice & control as well as possessions and standard of living),
- 3) Feelings of powerlessness,
- 4) Lack of adequate support system (potentially from avoidance/isolation),
- 5) Little or no preparation for the impending move,
- 6) Moderate to high degree of environmental change (i.e., similarity of former and new environments and how integral the environment is to self-esteem),
- 7) Severity of RSS increases with several recent transfers/moves,
- 8) Impaired psychosocial health status or cognitive decline (i.e., stress of move added to a pre-existing condition such as dementia, alcohol or drug abuse, delirium, personality disorder),
- 9) Significant health problems,
- 10) Communication difficulties between person moving and her/his primary caretaker (often a child) or other family problems,
- 11) Unrealistic expectations of the caretaker and person relocating, and
- 12) A poor male living alone is typically at greatest risk for development of RSS.

As one might observe from these stressors, the average older adult moving into a LTC facility would probably experience most (if not all) of these factors. Most new admissions to LTC facilities are not planned, but are due to recent loss of physical health and functional ability.

When moving from a private home into a LTC facility, the changes required of the person are typically much more demanding than a non-institutional change of residence. Changes from home into a LTC facility also encompass eating habits, social activities & living conditions, all of which have a higher priority for older adults than for other age groups. This can be devastating when such a change occurs in a surprising manner. Families and friends who do not tell the potential resident where they're going contribute to RSS. Families and friends can decrease stress by informing potential residents of their intent for LTC placement and by giving the potential resident an opportunity to prepare. Even in situations of coma, dementia, and delirium, loved ones can inform the person about an impending move and help prepare for it.

### **Adjustment to Loss**

Loss can be classified as primary or secondary. *Primary loss* is a loss that alters a person's relationships with others, or affects one's well-being or health (e.g., loss of one's health through illness or injury, loss of one's work role through unemployment or retirement, loss of one's spouse, children, or grandchildren, loss of long-time friends or associates, loss of one's own life). *Secondary loss* is a loss that is triggered by any primary loss, such as those mentioned above (including loss of independence, health, or ability to care for oneself on a day to day basis, the loss of one's role as a productive individual in the family or community, loss of one's sexuality or feelings of intimacy, changes in one's appearance, isolation from other persons, a decline in income or earning power, a decline in self esteem resulting from other secondary losses, etc.). Primary losses are most always recognized as real by family, friends, and the community, whereas secondary losses rarely are.

It is usually very difficult to be the primary caretaker of a spouse. This long-term stress can lead to the caretaker's death before the death of the spouse being cared for. When this happens, the surviving spouse not only must acquire a new primary caretaker, but must often relocate as well. As discussed earlier in this manual, the recent death of a spouse can contribute to development of RSS.

Many factors contribute to individual coping with the death of a spouse. Gender, socioeconomic status, education, age, and work history are a few among many. For example, men have difficulty asking for help, often lack self-care skills, and have few other older men on whom to rely for support. Women typically have more support than men, but they often lack job skills and face more age discrimination when attempting to provide their own financial support. In a situation as devastating as the death of a spouse, it is difficult at times to conceptualize what is normal. Normal, healthy grieving is painful, personal, lonely (more often than not), requires time and effort, and is a path to restored wholeness. Knowing normal from abnormal can assist with identification of those at risk (or currently experiencing) RSS. For example, it is definitely not normal to attempt suicide or become assaultive following the death of a spouse. Persons exhibiting such symptoms should be considered at risk for developing RSS as well as for self/other harm, and should be referred for mental health services.

Elizabeth Kubler-Ross, through her work in death and dying, created a model of how people handle grief and loss. These stages are all perfectly normal and can last years:

- 1) **Denial-** In the denial stage, one refuses to believe what has happened. S(he) tries to convince him/herself that life is as it was before the loss. S(he) can even make believe (to an extent) by reenacting rituals that were traditional with the loved one (i.e., making an extra cup of tea for the loved one who is no longer there, rushing home to tell the deceased that s(he) has met an old friend, flashing back to times and conversations in the past as though the deceased were present, etc.).
- 2) **Anger-** Anger can manifest itself in many ways. S(he) can blame others for his/her loss. S(he) can become easily agitated and have emotional outbursts. S(he)

- can even become angry with him/herself. Care must be taken here not to turn this anger inwards.
- 3) Bargaining- Bargaining can be within the individual or with a deity if the person is religious. Often s(he) will offer something to try to take away the reality of what has happened. S(he) may try to make a deal, to have the deceased back as they were before the tragic event occurred.
  - 4) Depression- Depression is a very likely outcome for all people that grieve for a loss. This may be the most difficult stage of the five to deal with. Feelings of guilt, listlessness and tiredness are common. One may be bursting helplessly into tears, and feeling as if there were no purpose to life anymore. One may also feel as if s(he) were being punished. Pleasure and joy can be difficult to achieve, even from activities that have always provided delight. Thoughts of suicide are also common in depression. There are many different ways in which this stage of grief can manifest itself.
  - 5) Acceptance- Acceptance is the realization that life has to go on. Here, one can accept the loss. S(he) should now be able to regain his/her energy and goals for the future.

Older adults who have difficulty adjusting to losses include:

- 1) Those who choose to be alone or isolated from others in the family or community,
- 2) Have a fragile, narrow view of themselves,
- 3) See themselves as having few friends or family members upon whom to depend,
- 4) Have poorer health than many of their contemporaries,
- 5) Fail to recognize that they are having a difficult time adjusting to loss,
- 6) Have difficulty reaching out or asking for help from others,
- 7) Have a history of not having coped with earlier losses, and
- 8) Attempt to solve their problems by blaming others or by turning to alcohol and drugs.

Not surprisingly, those older adults who have difficulty coping with loss share many characteristics of those with high probability of developing RSS.

Older adults who seem to cope adequately with losses:

- 1) Have positive, flexible views about themselves,
- 2) Are able to balance the positive and negative aspects of the loss they have experienced,
- 3) Have friends and family to whom they can turn for support,
- 4) Have experienced and adjusted successfully to life changes in the past (incidentally, those who have developed non-work centered interests earlier in life will have an easier time adjusting to retirement than those who haven't),

- 5) Live in the present. They are not preoccupied with the past, and have a positive view of the future,
- 6) Take good care of themselves physically, emotionally, and spiritually, and
- 7) Know when they need help from others and are able to ask for this help.

As management of emotions is culturally determined, Americans do not typically know how to navigate uncomfortable emotions, especially grief. Grief is as natural as eating and sleeping. Grief is not shameful or to be avoided any more than other feelings, such as happiness, anger, contentment, or suspicion. Grief is an emotion that like all other emotions provides information about a particular situation. Our responsibility is to move through the situation while learning from it what we can to better ourselves at the end. If loss occurs, a person will have feelings. And grief is not only experienced in relation to the death of a spouse or other loved one. Grief is also common as we recognize other losses, such as the loss of sexuality, the loss of feelings of intimacy, the loss of a friendship, the loss of possessions, changes in appearance due to the aging process, retirement, etc.

### **CHAPTER 3**

#### **Tips for Families**

Each family, hospital, retirement community, and LTC facility has its own culture, affected by socioeconomic status, payment source of the majority of residents, average cognitive status of residents, average physical status of residents, and many other factors. These individual cultures necessitate differing strategies to achieve the best adjustment outcome. Thus, the list that follows is a combination of steps that are most helpful to avoid RSS:

#### **Planning Ahead:**

With the help of an attorney, the following documents may be helpful in preventing RSS if prepared in advance of cognitive decline (or before other impairment is evident):

- 1) living will or trust (which might specify decisions regarding LTC),
- 2) durable general and medical powers of attorney (POA) (for emergency situations as well as cognitive decline),
- 3) advanced directive, and
- 4) designation of a primary contact person for emergencies and in situations of long term care (typically will also function as the POA).

The will and durable POA should designate primary and secondary designees for financial, physical and mental health care decisions and should specify for how long, when to enact, and who decides when to enact. It is important to recognize that a POA is typically not enacted until a physician determines **in writing** that the person in question is

unable to make medical or financial decisions for themselves. If deteriorating illness is a known factor and eventual need for long-term care is recognized, immediate planning for a move to allow the potential resident to make as many decisions as possible for her/himself would likely facilitate adjustment once moved. Although many facilities offer referrals to complete these documents upon move-in, this delay could create additional stress upon the primary caretaker(s) and resident during this already stressful time.

### **Prior to Any Move:**

Prior to making any move, the potential resident and family should ask the referring physician some questions to decrease guilt and potential confusion. For example:

- 1) Does this suggested move/need for more care mean my loved one is not going to improve (i.e., what is the prognosis)? Will they be permanently impaired? If yes, to what degree might s(he) be able to participate in his/her own care? If the doctor hedges or if the answer is unclear, ASK FOR CLARIFICATION!
- 2) How much care does the person need now? What are her/his options for the least restrictive environment? Is the person most appropriate for a retirement community, assisted living, LTC facility, or secured unit? Remember the goal is to *maximize autonomy*.
- 3) When do you think there will be a need for more care than they need now?
- 4) When does the move need to be made? Often the payer source determines some of this decision (i.e. the hospital can receive payment for a certain treatment period and/or diagnosis only).
- 5) What are the time limitations and the reasons for them? (ask this of social worker in hospital or potential LTC facility)
- 6) Ask friends and clergy of the person (and others who may be intimately connected) what their opinions of the person's functional ability are.
- 7) Adjust observations for limitations in sensory-perceptual disturbances and any temporary influence of illness (encourage use/acquisition of hearing aids and eye glasses, dentures, assure adequate lighting, etc.). Some improvements in sensory-perceptual disturbances could make a significant difference in the person's functional ability.

After gathering information regarding the potential move, a family conference is often helpful with every family member possible physically present. Present all accrued information at the conference. Ask all present to reveal their true responses to information gathered, feelings and misgivings. The spectator is always a potential critic. Whenever possible, focus the conversation towards the resident as their needs are the highest priority in this decision. Give those who are not present an opportunity to make their true feelings and misgivings known to the group.

Once a decision is agreed upon, speak with the person of concern. ***Don't*** hedge or lie. If the move is expected to be permanent, tell him/her so. Tell the person the whole story in terms of the person's needs as a priority (over wants), and allow her/him to respond. Remember to focus upon the needs of the person, not the needs of the family. A person

may avoid confronting his/her needs in the form of "how can you do this to me!" and/or "I'd rather be dead than go to a nursing home!" Remember- these questions do not change the person's care needs or the consideration of long-term care. **This process should not be resolved in only one day.** Allow the person time to adjust to the idea prior to the move. This confrontation should happen regardless of the condition of the person.

### **Moving In With Family**

Good practices for an older adult's move into another family member's home include the whole adult family taking part in responsibilities for care (physical, financial, transport, etc.). Thus, it is imperative that all current residents of the home in which the person will move be consulted at length and be in agreement. Moreover, extended family, such as adult siblings of the host family, should be consulted regarding the relocation. In the best care scenario, extended family will also agree regarding placement and would be willing to assist with care. Unfortunately, the least successful method of relocation into another family member's home is also the most common, wherein the female head of household assumes full responsibility for care.

It is also a good practice to enter into a contract with each involved family member regarding the care of the loved one in need and the responsibilities of each family member (i.e., time-sharing, financial split, etc.). New roles should be clearly defined, and all questions asked and answered prior to signing any agreement. Still, even in the best scenario, a senior in need of care should ask her/himself:

- 1) Would I want my family/children taking on the responsibility of caring for me?
- 2) Would I be comfortable in someone else's home?
- 3) How much of this decision is being made with a feeling of obligation or need to sacrifice?

If the person has any misgivings regarding the answers to these questions, s(he) might benefit from exploration of alternative community placement prior to relocation. One might call an area LTC ombudsman, commission on aging, mental health association, or even the Texas Department of Human Services to help choose an appropriate placement.

### **When a Facility Is Selected**

Again, foremost among considerations in the placement decision should be the person's needs. The person should be a part of the entire process if possible, with lengthy discussion of what individual preferences are between facilities, what each family member visiting may or may not have noticed, and its relative importance to the person's needs. Including and welcoming all family members in the choice of a facility encourages continued family involvement following relocation and minimizes potential guilt and criticism among family members. After the person's needs, the next consideration is typically how far the facility is from potential visitors. Family involvement can minimize stress, and is integral to a person's avoidance of (or at least speedy recovery from) RSS.

After thorough exploration of available facilities and decision-making, the person might ease into residence by attending days only in the facility for at least 2 weeks before admission. The person can use this time to form social circles for support as well as to direct packing for the move. The potential resident her/himself (if able) should determine what to pack, what to leave, and where to leave items. All involved family/friends should determine with the potential resident how continued access to items will be negotiated.

During this time, friends and family should also define new roles for themselves in the person's life. A LTC facility cannot meet all needs for any resident. At this time, the family should question what the resident has learned about needs of other residents residing in the facility, and plan accordingly. Residents often request some personal items be bought rather than use the items provided by facility (such as preferred protective undergarments, hygiene items, sheets, blankets, etc.) to ease adjustment. Together with the resident, family and friends should decide who, what, when, where and how to meet these requests. This in itself may begin to define new family roles for the welfare of the person. Other considerations include:

- 1) Who will attend care plan meetings?
- 2) Who will attend family dinners and other recreation events?
- 3) Who will bring resident on outings, and how often?

The resident, family and friends could reduce RSS by sending change of address notifications to all regular correspondents prior to the move. Financial dealings (credit cards- maintain only one in a safe place, bank accounts, life/health insurance, stocks/bonds, land holdings, taxes, house and furniture, personal property, social security, and other assets) should be clarified with all involved family prior to the resident's permanent placement. The resident and family can also prevent or reduce RSS by assisting the person to maintain contacts with the outside world. For example, does the potential resident enjoy a magazine or daily newspaper? Frequent the local library or video rental store? Change indoor plants according to seasons? Require cable TV? Need her/his own telephone line? Enjoy the internet? The largest part of avoiding a feeling of imprisonment and maintaining a sense of security and purpose is maintaining these regular ties to the outside world.

## **Chapter 4**

### **Tips For Facilities**

#### **Environmental Layout**

Although a building is not usually rebuilt to accommodate the newest research on facilitating adjustment, it is important to recognize what physical and environmental characteristics reduce the frequency of RSS among new and other relocating residents. The wagon wheel design of many LTC facilities can be very confusing for normal, healthy people. Thus, this design leaves much for which to compensate for new residents who possess physical, cognitive, or sensory difficulties. Studies have shown the

following to be effective means of environmentally counterbalancing such difficulties to reduce incidence of RSS:

- 1) Providing equal attention to the 5 senses (taste, touch, sight, smell, sound). This can be accomplished with liberal use of indoor and outdoor plants, automatic scent dispensers, differentiating the textures of walls from floors from furniture from spreads and other objects, flowers, animals, fish, birds, and a variety of music (not just religiously oriented!),
- 2) Welcoming frequent visits from children, whether in family or as elementary classroom visits or school-age performances of dance, music, sports, etc.,
- 3) Welcoming pets to continue residing with the new resident,
- 4) Large print calendars and clocks in all resident rooms and group meeting facilities,
- 5) Establishing familiar landmarks for different halls and group activity rooms,
- 6) Making residents' room door colors different from the wall, with large name labels on the door a different color from the door,
- 7) Using color and style (even designating a 'theme') liberally to differentiate halls (style could also contribute to how the individual facility wishes to define its culture, and sends a message to residents- thus, 'clean prison' is not a style that communicates wishes for happiness and home),
- 8) Making the toilet seat and handle an opposite color from the toilet,
- 9) Posting all signs in large print at mid-eye level and lower to accommodate both ambulatory and wheelchair-using residents,
- 10) Posting smoking areas, rules, and times in several areas in large print
- 11) Making call lights and telephones an opposite color from the wall and bedding, with cords long enough to reach the foot of the bed,
- 12) Allowing each individual resident to choose where s(he) would like to sit for meals, and once chosen placing their name in large print with a photograph under plexi-glass at their regular table,
- 13) Allowing each resident to personalize his/her room with layout of furniture as well as bedspreads, pictures, rug, curtains, furniture, etc. Residents who have few possessions might benefit from donations of decorative items, which they may place as they choose,
- 14) Mounting to the wall beside the telephone at sitting eye level a dry-erase or bulletin board or laminated paper with large print of family and friends' telephone numbers,
- 15) Making available currently relevant orientation brochures with pictures,
- 16) Making 3-D model of facility (or directory such as one might see in a mall) available in common areas to assist with location,
- 17) Making a video of the facility with interviews of staff and residents for families to bring to potential residents who cannot preview the facility in person, and

- 18) Providing each resident with a large drawer on which they may place their own lock to keep valuables or precious items, though in general items of great monetary value are discouraged in LTC facilities.

### **At First Contact**

Interpersonal skills are extremely important in reducing RSS, and should be evident from first contact. Such skills include, but are not limited to:

- 1) Open, friendly body language (no crossed arms or legs, leaning forward when listening, smiling, nodding understanding, etc.)
- 2) Tone of voice should be loud enough for all involved to hear, but not abrupt or abrasive (i.e., watch sarcasm, even when joking, and do not patronize debilitated residents),
- 3) Using common courtesies, such as "please," "thank-you," "may I," etc. NEVER attempt to move a slow-moving older adult 'out of the way' without first asking permission to assist,
- 4) When an answer is not known, communicate this as well as your intent to direct the involved parties to the appropriate staff member to answer this question (when duration of first contact is longer, a notepad to jot down some unanswered questions can be helpful), and
- 5) Give all involved parties permission to bring questions and concerns to appropriate staff, and introduce and provide a list of department heads and their general duties.

The RSS frequency can be limited by reducing stress secondary to paperwork. All necessary paperwork should be gathered into an admission packet, and clearly defined with purpose, due date, and to whom it must be submitted (with telephone numbers if an appointment is necessary). This necessary paperwork most often includes legal documents that may or may not have been completed by the family (for example, power of attorney, DNR, living will, etc.). Many facilities operate under the belief that because a power of attorney has been executed, it is automatically enacted. In many cases, this is not so. The help of an attorney may clarify what procedures to follow regarding observance of powers of attorney, as well as what decisions the power of attorney allows the resident to make for him/herself. To reiterate a previous passage, the following documents may be helpful in preventing RSS if prepared in advance of cognitive decline (or before other impairment is evident):

- 1) living will (which might specify decisions regarding LTC),
- 2) durable general and medical powers of attorney (for emergency situations as well as cognitive decline), and
- 3) advanced directive.

The will and durable POA should designate primary and secondary designees for financial, physical and mental health care decisions and should specify for how long, when to enact, and who decides when to enact. If possible, a facility may benefit from providing this information to prospective residents and their families at first contact to provide ample time for completion of these documents.

First contact may also be used to measure goodness of fit of the potential resident to the facility. Although every facility would like to maintain a 'full' status, it is much more important to ensure goodness of fit to maintain those full beds as well as to decrease potential RSS. One might ask a potential resident, "What needs do you have currently? What wants to you have? What do you truly think of this place? Can you picture yourself living comfortably here? Do you see others you feel you could identify with? Do you have any questions or concerns regarding our more confused residents? What kind of things do you expect of the staff here? What kinds of activities do you enjoy? What, how much and when do you like to eat? What does your average day look like? What are your ADL routines? What are your sleep patterns? When compared with our schedule, how do you think the two match? What are your expectations regarding a physician, dental, optical, audiology care?" In general, the facility representative should explore the potential resident's and family's expectations of the care that s(he) will receive. One might also use this time to invite the potential resident and her/his family to share a meal in the facility, join in some group activities, and/or become a day-only resident for a short time. This might allow the potential resident and family and make as informed a decision as possible, as well as provide other family members or friends the opportunity to participate in the admission and decision-making process (thereby allowing the facility to make as informed a decision as possible). If a person has difficulty making a decision regarding goodness of fit, it may be helpful to provide them with a list of advantages and disadvantages (i.e., needing a physician's order for all medications- even over the counter, vs. having all medications brought at the prescribed time in the prescribed amount) of a move as discussed, with room for the person and his/her family to add future thoughts. This list might also be accompanied by a reference to a family member or current resident who might be willing to speak with prospective residents and their family.

### **Pre-admission**

When it is determined that the person may be a good fit for the facility, make sure to highlight differences of living in the facility than living in the person's previous environment, with advantages and disadvantages clearly labeled. What was their living situation before? Who came to visit? Where did they go and what did they do? How might those things be impacted by a move? What could be done to maintain (as closely as possible) such routines after a move? If a memory problem exists, staff might suggest bringing a diary upon admission to assist with tracking activities, locations, people, meals, etc. This diary could also be useful when this resident attempts to relay to family what s(he) has been doing in their absence.

To decrease risk of RSS, it may be useful to identify previous coping patterns of a potential resident. Ask the potential resident and her/his family what that person does in times of pain, anxiety, depression, stress, anger, etc. Document their report and your observations and consult with relevant staff who may be able to intervene when a person has difficulty coping. Include the potential resident in assessing existing problems (physical, emotional, interpersonal, cognitive) and developing a care plan. With both the potential resident and existing resident's permission, staff might collaborate on

determining who might be a suitable "buddy" for the new resident (i.e., another resident who might be available to show him/her the ropes). This in itself may prove the difference between an easy and difficult adjustment.

When a person is moving from one LTC facility to another, it may be useful to minimize any RSS by assisting with any reimbursement due to the resident from the prior facility. Also, records from the prior facility may provide much needed information and reduce paperwork required of the potential resident and her/his family.

### **Admission and First Week**

Before the new resident arrives, make sure the room is assigned properly and is ready for move-in at the scheduled arrival time. The room should have a schedule of activities already posted, and a list of facility rules and resident's rights, a document on keeping personal possessions safe, and perhaps a brochure with the facility layout.

If the resident is being admitted from another facility, a transfer sheet identifying pre-morbid and current functioning should accompany her/him. A current nursing care plan and telephone report from the nurse in the previous facility to the receiving nurse in your facility will provide clarity of information and greater continuity of care. If these are not received, it is important to encourage the appropriate staff to make contact with the transferring facility to gain the needed information.

The person's nurse and aid should be present at admission to conduct a nursing assessment. This assessment should include a thorough review of the resident's normal daily routines (if not already conducted), which can be used to tailor a nursing care plan and the resident's schedule to parallel a pre-move lifestyle.

At this time, the new resident might be encouraged to unpack her/his own belongings as much as possible, with offered help from facility for unmanageable/difficult objects. Unpacking symbolizes taking an active role in his/her future, arriving home, and facilitates knowing where her/his belongings are kept. Staff should re-introduce themselves, roommates, and other residents, re-orient the resident to facility layout and schedule, and remind the resident how to get his/her needs met. If the diary is not being used, staff might assist the resident by demonstrating its use (i.e., writing a greeting with their name, title and date on the first page).

Activities staff may assist new residents in adjustment by:

- 1) meeting with the resident,
- 2) conducting a thorough evaluation of enjoyed activities,
- 3) reminding the resident of ongoing activities,
- 4) inviting the resident to attend activities in person for the first week,
- 5) providing an opportunity for the new resident to participate in schedule design,
- 6) introducing resident to other residents of similar functional levels,
- 7) scheduling an "introduction time" into the beginning of each activity (i.e., is there anyone here who doesn't know ..."), and

- 8) developing an "activities buddy" system, in which compatible residents are matched to attend activities or conduct independent activities (i.e., dominos, bridge, music participation group, book club, etc.).

Though documentation is often troublesome, staff may find it useful to document how many staff interact directly with the resident from the first hour through the third day. This tracking enables the staff to maintain close interpersonal contact for the first few days (which facilitates adjustment), and to develop a thorough baseline assessment of the resident. Any problems, concerns, or questions should be documented and addressed as soon as possible, with follow-up on resolution success and further documentation.

Social services may find it useful to meet with the new resident and family during admission, then with the resident each day within the next week, and each week for the first month. This might ensure satisfaction with the relocation and provides a follow-up on the impact of the move on the resident's life and relationships. This might also provide an opportunity to address other concerns that may have developed since admission. When concerns are expressed, accept them as legitimate. Follow up with appropriate staff, provide feedback on the follow up, make suggestions on how the situation may be prevented in the future (with appropriate consultation), and document the interaction.

All departments interacting with the resident should monitor and document progress towards adjustment within the first day, week and month. Part of this documentation may include the residents previously noted coping style, strengths and weaknesses, and any noted need for intervention (i.e., watch for signs of depression, thoughts of suicide, anxiety, anger, etc.). Some LTC facilities have found moderate success in reducing RSS by developing reminiscence groups and guidelines for a successful visit for friends and family. As the new resident has endured many recent changes, old coping skills may be very useful to revisit in a reminiscence group, and may provide a sense of continuity to the resident as well as an opportunity to meet others of a similar functional level. And, if the new resident her/himself is changing, the family may find guidelines on successful visits very helpful.

### **How To Help The Family**

As the family is typically the primary source of interpersonal support for residents of LTC facilities, it is important to provide information to the family on how to assist their loved one through the relocation process. New residents also often take emotional cues from their family, and thus an anxious or sad family member equates to an anxious or sad resident. As soon as possible, staff should share information with family about the usual progression of RSS and related factors to reduce potential family contribution to RSS and perhaps avoid RSS. Still, often a loved one is aware of RSS already present, but does not know how to intervene. Aside from a referral to an appropriate mental health professional, staff might encourage the loved one to avoid arguing with the resident- they may only become defensive about their position. Encourage the family to acknowledge the resident's thoughts and feelings, and ask what the resident may need

from others. If the resident has a ready argument for why nothing will help and nothing will work, the family might ask the resistant person "do you want to get well"?

Central to RSS is a feeling of hopelessness, which loved ones may unintentionally encourage by accepting a new resident's assertion that "I came here to die" and/or "my life is over." Loved ones of a new LTC resident may benefit from facilitation of the idea of lifelong development. For example, development can be emotional, psychological, cognitive, or physical, and does not stop in young adulthood. Development can continue. Also, the resident and loved ones may benefit from determining how the resident determines their individual worth. If the resident's definition of worth is how much money is made in a year (or other tactile definition), loved ones can contrast it with the idea that worth is in who we are. Worth is not necessarily in what we do or have done. Development does not stop at a certain age. We develop as long as we are breathing, and everything that happens to us is part of development. How we choose to continue developing may determine our worth. Family could also be encouraged to spend some time with their loved one pointing out what value the resident has been to her/him. Of course, if the new resident is severely demented, s(he) may not be able to comprehend the idea of worth. In cases such as these, family and friends might be encouraged to allow themselves to mourn the loss of who their loved one once was to be able to accept the confused person's reality. Relating to the severely demented from their reality would likely be more effective than arguing or repeated correction.

Also very effective at minimizing RSS, loved ones may always be encouraged to attend a relocation orientation meeting with their family member, regular activities, meals, and outings by providing the primary contact person with a monthly schedule of activities along with a brief greeting and invitation to attend. Still, many facilities have found success in minimizing RSS by developing a regular schedule of family-oriented activities (such as family dinners, outings, concerts, sports activities, etc). The primary contact person could be encouraged to develop a system to alert other involved individuals in the resident's life to both regular and special activities. Yet the primary contact person should be made aware that if telephone calls, visits, and outings are conducted separately and spaced evenly on a schedule, the new resident may feel more supported. And of course, if a new resident has a spouse who may visit, the facility might support such interaction by providing privacy time with her/his spouse. Even if a new resident has a satisfactory support system, but ESPECIALLY if a resident does not, a network of volunteers may supplement visits by significant others in a resident's life. Volunteers may seem a very small intervention in an individual resident's life, but can become the small intervention to make the most difference in avoiding RSS.

Lastly, LTC facilities may assist families by proactively reaching out to offer presentations to referring social service agencies for families of hospitalized persons. These presentations could encompass caring for aging parents, when LTC is indicated, how to find a good nursing home, how to discuss the situation with a parent, and how to deal with the guilt, among many other useful topics.

## **CHAPTER 5**

### **Responding to relocation stress disorder**

Once an older adult is identified as having several characteristics of RSS, a loved one, physician or social worker should approach the person regarding referral to a mental health professional. Though many people view such a referral as indicative of "I'm crazy," this referral could be reframed as an opportunity to address and reduce any uncomfortable feelings the person might be enduring needlessly.

A person may wish to avoid the perceived stigma of mental health services and choose to "wait it out." And factually, "waiting it out" may result in some reduction in symptom severity or frequency. However, doing nothing most often results in simple acceptance of a chronic, mild depression instead of adaptation to the new environment and eventual healthy adjustment. Moreover, untreated RSS may result in spontaneous recovery of symptoms with room changes and admissions to and from the hospital.

Yet, whether the person does or does not agree to mental health services, some interventions by both family and LTC facilities have been shown to be effective in addressing RSS and increasing the potential for a healthy adjustment. These interventions include, but are not limited to:

- 1) Ask the person's physician to review medications for potential pharmacological contributions to symptoms,
- 2) Provide reorientation cues frequently (if needed),
- 3) Encourage the person to talk about his/her expectations, anger, disappointments, and other feelings regarding the move,
- 4) Monitor eating and sleeping,
- 5) Provide as much choice and control as possible,
- 6) Limit mass and individual moves (i.e., both room-to-room and buying another home),
- 7) Increase preparation for any future changes in the environment as much as possible (for example, "I'll be home later than usual tonight" or "we're canceling the regular BINGO activity next week to make room for a special concert"),
- 8) Increase both awareness of and practice of different coping strategies,
- 9) Retain familiar items (clothing, furniture, bedding, etc.),
- 10) Preserve the person's former schedule and routine as much as possible,
- 11) Provide post-move support as much as possible (increased telephone calls, visits, encouragement of other friends/family to call or visit, increased outings according to pre-move preferences, etc.),
- 12) Facilitate trust with an open, accepting, respectful, and caring demeanor (always please and thank-you, may I, will you, always knock before entering their room, and when memory problems are evident- always say "Hello, my name is \_\_\_\_\_. I am your aid/daughter/administrator/social worker/etc., and I'm here to \_\_\_\_\_."),

- 13) Do not argue. Acknowledge the person's opinion and feelings and then demonstrate healthy coping for the person (i.e., "wow! You sound really angry about this shower! What do you suggest we could do to make it better for you?"),
- 14) Never say "No" to a demented resident. Present choices (three or less). For example, "well, bananas would be very nice today. What would you think about having either strawberries or oranges? Of those two, which would you prefer?",
- 15) Do not give orders. Ask for cooperation pleasantly and politely,
- 16) Don't take the person's behavior personally. It is about their adjustment to the move, not about you as a person. This enables you to interact with the agitated or angry person more effectively,
- 17) Use praise liberally (for example, "good job with that painting! What would you think about letting us put it on the wall in the hall so that everyone could enjoy it?"),
- 18) Joke with the person, but not at her/his expense. Find humor in everyday happenings (depending upon the individual- if they weren't very receptive to humor before the move, they aren't likely to be afterwards), and
- 19) All persons involved in direct care should make it a point to "just visit" with a new resident for 5 minutes each day for at least 2 weeks. This allows the new resident to develop a sense that direct care personnel do not only talk to him/her when they need him/her to do something.

Within LTC, staff may further intervene to minimize existing RSS by:

- 1) Formal documentation of RSS symptoms, interventions, and success of adjustment daily for the 1<sup>st</sup> 2 weeks, then weekly for 6-8 weeks thereafter, then monthly for the next 6 months,
- 2) Develop a symptom checklist to administer to each new resident within the first 2 weeks of admission, intervene appropriately, document noted symptoms and intervention, follow-up and then document follow-up
- 3) Include in the plan of care strategies to minimize emotional distress related to relocation. Within the first 14 days, expected outcomes might include
  - a. "resident will socialize with family, staff and residents,"
  - b. "pre-admission weight, appetite, & sleep patterns will remain stable" (unless dysfunctional, then expectation would be to develop more appropriate health patterns),
  - c. "resident will verbalize feelings, expectations, and disappointments openly with members of the staff and/or family," and
  - d. "\_\_\_(inappropriate behaviors) will not occur."

Within 3 months, the plan of care might change to include:

- a. "resident will independently move to and from areas within facility,"

- b. "resident will react in a positive manner to staff efforts to assist adjustment,"
- c. "resident will express concerns about placement when encouraged,"
- d. "resident will verbalize and demonstrate an understanding of facility routines,"
- e. "resident will recognize and know the name of at least 1 staff member," and
- f. "resident will not develop physical and/or psychosocial disturbances indicative of RSS."

Within 6 months, the plan of care might change to include:

- a. "Resident will verbalize acceptance of need for placement,"  
and
  - b. "Resident will indicate acceptance through body language."
- 4) Provide training to staff on helping new residents adjust. Often in LTC facilities, the persons with the most direct contact with the residents (Aids) do not have access to charts to document observations. Training provided might also address how the facility prefers aids to ensure documentation occurs regarding their reports of symptoms of RSS,
  - 5) Offer the family or friends an opportunity to stay overnight and/or for meals for the first 2-3 days,
  - 6) Encourage loved ones to participate in family council, and finally
  - 7) Encourage the resident to participate in resident council.

Though the above interventions are not comprehensive and should not hinder individual creativity when relating to individuals with RSS, it may provide some helpful information with which to open a dialogue aimed at minimizing RSS and encouraging healthy adjustment to a difficult change.

\*Key to Abbreviations\*

RSS = Relocation Stress Syndrome  
POA = Power of Attorney  
LTC = Long Term Care  
ADL = Activities of Daily Living  
DNR = Do Not Resuscitate  
3-D = 3 dimensional

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