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Perspectives, Journal of the Canadian Gerontological Nursing Association, (Formerly, the Journal of the Gerontological Nursing Association Ontario), welcomes original manuscripts describing issues, research and clinical or educational innovations of interest to nurses and others caring for older people. Manuscripts from nurses, other health professionals or other interested parties will be accepted for review. The journal also invites brief submissions of approximately two typed, double spaced pages, describing clinical practice tips, reviews of books or DVDs, creative works and letters of opinion to the Editor.

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Spring – Feb. 1; Summer – May 1; Fall – Aug. 1;
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ISSN 0831-7445

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Perspectives is a refereed journal published quarterly by the
Canadian Gerontological Nursing Association.
A few months ago, Canadian Nurse published an article written by a professor from Humber College in Ontario (Aka, 2013). Sharon Aka wrote, “Dance with me”, a reflective piece on the often unrecognized and demanding work of long-term care nursing. Aka, with a background in acute surgical nursing, had decided to do casual employment in a long-term care facility to meet her need for practice, to educate herself and to become a better teacher for her undergraduate students whose clinical placements were in long-term care. Aka was shocked by the responsibilities that she held for so many residents and by the complexity of care decisions that faced her. Hers is a meaningful reflection for many gerontological nurses who handle heavy responsibilities both in acute and long-term-care settings. Like Aka, I also teach undergraduate students and one of their two 6 week placements is in a personal care home, and I believe that Aka’s article should be required reading for these students.

We have known for some time that working in long-term care is a mixture of “feeling appreciated and valuable, whilst at the same time feeling underestimated and frustrated” (Karlsson, Ekman & Fagerberg, 2009, p. 265). We also know that for student nurses, a career in gerontological nursing is not a priority. In their literature review, Neville, Dickie and Goetz (2014) reported findings from seven countries saying that four key issues were relevant to student nurses’ career choice not to work with older adults and instead to favour pediatrics, obstetrics/midwifery and critical care. These four key issues are: societal values about aging that emphasize negativity; undergraduate nursing curricula that lack gerontological content and qualified instructors; clinical placements that lack professional mentorship; and working conditions within the health care sector that create problems for recruitment and retention (Neville, Dickie & Goetz, 2014).

It has also been suggested that the nursing profession as a whole has shifted its focus from “caring” to “curing” with the result of devaluing areas of care such as gerontological nursing where “cure” may not be possible (Brown, Nolan & Davies, 2008). Whether or not this shift follows from or is concurrent with the broader societal valuing of technology and youth are questions for debate. In this issue of Perspectives, the feature article by O’Brien, Wells, Welsh, Wells and Cake (2014) describes Protective Community Residences (PCRs) in Newfoundland and Labrador and a philosophy of care “that focuses on quality of life and finding purpose in daily activities rather than on physiologic rehabilitations and ‘cure’” (p. 12), and that seems to be the essence of nursing practice in long-term care.

Also in this issue, an article reports on a health care aide led quality improvement project that had implemented a care improvement intervention in seven long-term care residential facilities in Alberta and British Columbia. This “Research Snapshot” by Cranley, Estabrooks, Wagg, Norton and Yeung (2014), reminds us that quality improvement projects require vigilance and support if they are to be sustained and diffused in long-term care. Our “Clinical Corner”, authored by Cameletti (2014) highlights several community engagement strategies to enhance the health and well-being of older adults that have been implemented by a hospital in northern Ontario.

Lorna Guse, RN, PhD

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The vision of CGNA is to promote excellence in gerontological nursing through leadership, knowledge, and scholarship.

The vision of the Perspectives Journal is to be the premier Canadian journal in gerontological nursing.

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Lorna Guse
Editor, Perspectives
IMPACT OF RELOCATION FROM HOME OR INSTITUTION TO ASSISTED LIVING ON ADULTS WITH MILD TO MODERATE DEMENTIA

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ABSTRACT

In 2008, Western Health, one of four regional health authorities in Newfoundland and Labrador, implemented a new model of care for individuals with mild to moderate dementia known as the Protective Community Residences (PCRs). The PCRs were specifically designed to meet the environmental, functional and psychosocial needs of individuals with mild to moderate dementia. Being the first health authority in the province to introduce this alternative care model provided a unique opportunity to explore the impact of relocation and implications within the context of the health care system. This quantitative study examined changes in functioning in individuals who were relocated from private homes or institutionally based care to the PCRs. Standardized instruments were used to measure aspects of cognitive, behavioural, and functional abilities prior to relocation and within 6-8 weeks following relocation. Although not statistically significant, improvements were noted in functional abilities and in specific behaviours. Slight deterioration, although not significant, was observed in cognitive functioning. These findings suggest that a model of care that promotes purposeful activities and social interactions may have a positive impact on overall function of individuals with mild to moderate dementia. These findings will be of interest to policy makers and administrators involved in future program planning and care delivery models for individual with dementia. The population of Newfoundland and Labrador (NL) is aging at a rate faster than the rest of Canada. In 2011, 16% of the province was aged 65 or older (Statistics Canada, 2011) and this percentage is projected to increase to 20% by 2016 (Government of NL, 2008). It is well recognized that age is an irreversible risk factor for dementia. As the population ages, the prevalence of the population with dementia is expected to rise. It is estimated that 500,000 Canadians currently suffer from dementia; projections suggest that within 20 years the prevalence of dementia will double, affecting 1.1 million Canadians (Alzheimer Society of Canada, 2010). The purpose of this paper is twofold: a) to introduce an innovative housing option for people living with dementia, and b) to present the results of a relocation study that focuses on changes in cognition, function, severity of dementia and behaviours within 6-8 weeks following the relocation. Implications for decision-makers, clinicians and future research are reviewed.

BACKGROUND

Prior to 2008, the care choices in NL for individuals with dementia were limited to institutional-based care, personal care homes (assisted living) or home with supports. The only alternative when exit seeking behaviors limited an individual’s ability to reside in his/her home was facility-based nursing care. Facility-based nursing care is designed for individuals with high care needs who require on site professional health services (i.e. registered nursing staff). This care option is not always the most appropriate or cost effective for individuals with mild to moderate stages of dementia, as most of these individuals require supervision in a secure environment with limited professional and medical supports (Hawes, Phillips, & Rose, 2000; Hughes, McDonald, Barrett, & Parfrey, 2008; Leon & Moyer, 1999). Individuals with early to moderate stages of dementia function well in an environment that promotes a more psychosocial model of care than one that is medically orientated (Sloane et al., 2005; Zimmerman, Sloane, Heck, Maslow, & Shultz, 2005).

A review by Parfrey and McDonald (2005) examining institutionally-based long term care (LTC) in the Western Region of NL found that 15% of residents in institutional care had mild to moderate dementia as the only indicator for admission. It was suggested that these residents would be more appropriate for an alternative living arrangement where their care needs could be met, namely the supervised care plus option. Supervised care plus refers to a setting specifically designed to meet the
environmental, physical and psychosocial needs of the individual with mild to moderate dementia (Stuckless, 2001).

In 2008, the first supervised care plus option for individuals with dementia was introduced in Western NL. The setting for this option is four single dwelling bungalows located in a residential neighborhood. Each bungalow, referred to as a Protective Community Residence (PCR), provides a home and support option for 10 individuals with mild to moderate dementia. The design and operational features provide a supportive environment for individuals with dementia, as identified in the literature, were applied to operational planning related to the dementia care bungalows. These key design and operational features include a psychosocial model of care emphasizing choice and promoting the use of functional abilities through purposeful activities and social interactions (Chappell & Reid, 2000; Werezak & Morgan, 2003; Wood, Harris, Snider & Patchel, 2005), a home-like environment with effective signage and multiple cueing (Calkins, 2001; Day, Carreon, & Stump, 2000; Gibson, MacLean, Borrie, & Geiger, 2004), a staffing model that supports social environment as opposed to a medical/care environment (Schwartz, Chaudhury, & Tolfe, 2004), specialized staff trained in dementia care (Chappell & Reid, 2003), effective leadership for the support team (Day, Carreon, & Stump, 2000; Swagerty, Lee, Smith, & Taunton, 2005), standardized eligibility criteria for admission, and ongoing assessment using objective measures to determine need for transition to different levels of care (Teresi, Holmes, & Ory, 2000).

Each PCR has common and private living spaces to meet the needs of individuals with dementia. Figure 1 illustrates the floor plan of each of the four bungalows. As important as is the physical design of the PCRs, the approach and skills of staff are vital for the residents to experience quality of life (Day, Carreon, & Stump, 2000; Swagerty, Lee, Smith, & Taunton, 2005). Based on the experiences of other assisted living facilities such as British Columbia, Canada (MacCourt, 2008) and Sweden (Annerstedt, 1997), the ratio of personal care attendants (multi-skilled workers) to residents is as follows: during 12-hour days 2:10, and during 12-hour nights 1:10. The personal care attendants oversee activities of daily living and personal care, and are responsible for routine tasks such as meal preparation, housekeeping, and laundering. During the day, a Dementia Care Coordinator (Nurse Practitioner) provides clinical leadership in the PCRs and during the night, clinical leadership is provided by a Licensed Practical Nurse. A part time social worker, full time recreation worker, and a building care-taker are also included on the staffing team. Hutchings et al. (2011) provide further details of the physical design and care model utilized within these PCRs.

To be eligible for admission to and continued stay in the PCR, an individual must: 1) be diagnosed with mild to moderate dementia as measured by a score of 11 - 23 on the Folstein Mini Mental State Exam (MMSE) (Crum, Anthony, Bassett, & Folstein, 1993; Folstein, Robins, & Helzner, 1983); or 2) have a Global Deterioration Scale (GDS) score of 5 – 6 (Auer & Reisberg, 1997); 3) not demonstrate unpredictable, violent, sexually aggressive or disruptive behaviors; 4) not be a danger to themselves or others; 5) have a demonstrated need for protective supervision (e.g., wandering and/or exit seeking behavior, etc.); 6) not require chemical or physical restraints; 7) be able to ambulate and transfer independently (e.g., assistive devices such as canes and walkers); 8) be medically stable without co-morbidities that require frequent medical intervention. The introduction of the PCRs provided a unique opportunity to assess changes in behaviors,
cognition, and functioning of individuals with mild to moderate dementia relocated from a private or personal home, or institution to this enhanced assisted living environment.

LITERATURE REVIEW

Research demonstrates that relocation of older adults from home or institution to assisted living or LTC, between LTC facilities and within LTC facilities can result in adverse psychological, emotional and physical health effects. Relocation of older adults has been correlated with medical conditions such as stress (Freidman et al., 1995; Walker, Curry, & Hogsetl, 2007), anxiety (Jackson, Swanson, Hicks, Prokop, & Laughlin, 2000; Thomasma, Yeaworth, & McCabe, 1990), and depression, insomnia, and gastrointestinal disturbances (Jackson et al., 2000). Increased mortality (Aneshensel, Pearlin, Levy-Storms, & Schuler, 2000) and falls (Hodgson, Freedman, Granger, & Erno, 2004) have also been reported. In addition to these negative consequences, residents sometimes feel a sense of personal loss in terms of material possessions following relocation (Nay, 1995). Given the adverse impacts associated with relocation, significant efforts should be made in planning the relocation process to reduce or eliminate these negative outcomes.

Strategies to minimize the potential for negative relocation implications have been explored in the research. To reduce the stress associated with relocation, Kao, Travis, and Acton (2004) suggest interventions to ease the transition to institutionalization in three phases: pre institutionalization, immediately after institutionalization and post institutionalization. The research on successful outcomes of relocation of older adults contains common elements including resident and family participation in the planning for relocation, resident and family choice, continuity of staff during the move phase, ongoing communication with staff, residents, and families, and resident assessment and monitoring following transition to a new environment (Davies, 2004; Hutchings et al., 2011; Jackson et al., 2000; Kellet, 1999; Melrose, 2004; Strang, Dupuis-Blanchard, Nordstrom, & Thompson, 2006).

Although numerous studies have been conducted on relocation impacts and strategies to alleviate adverse outcomes associated with relocation, very few studies have been conducted on the impact of relocating individuals with dementia from private or personal home or institution to assisted living models. Systematic evidence regarding the effectiveness of an assisted living model (i.e., supervised care plus) for individuals with mild to moderate dementia is also limited.

Research, however, has demonstrated that quality of life and functional ability of an individual with dementia are influenced by both the physical and psychosocial environments (Cohen-Mansfield & Werner, 1998; Day et al., 2000; Morgan & Stewart, 1999; Nazami & Johnson, 1992; Schwartz, Chaudhury, & Tolfe, 2004; Teresi, Holmes, & Ory, 2000). An Alberta-based study concluded that quality of life for individuals with mild to late dementia was the same or better in purpose built assisted living residences when compared to traditional nursing home settings (Reimer, Slaughter, Donaldson, Currie, & Eliasziw, 2004). A British Columbia based evaluation of a licensed dementia care home for older adults identified the following emerging themes six months post establishment: high family satisfaction, high degree of staff satisfaction, and a higher level of function in the residents compared to those residents who moved to complex care (MacCourt, 2008).

METHODS

Sample

A purposive sample of the initial 41 residents who relocated to the first three PCRs was used in this study. As of July 2011, all four PCRs within the regional health authority were occupied. All individuals who relocated were considered for inclusion in the study.

Study Design

Ethics approval was received from the Western Health Research Ethics Board prior to commencing this study. The data were being collected on residents as part of the application for admission and continued stay in the PCRs. Because this study conducted secondary analysis on data already being collected as part of the normal assessment process, a separate signed consent was not required.

Sociodemographic data (age, gender, and prior living arrangements) were collected as part of the application process for admission to the PCRs. Standard assessment tools were used to provide measurements of behavioral, cognitive, and functional abilities. These assessments were conducted by one of two trained clinical staff persons prior to admission and 6 – 8 weeks post relocation. These instruments included the GDS (Auer & Reisberg, 1997; Paul et al., 2002; Reisberg, Ferris, Leon, & Crook, 1982; Reisberg, Sclan, Franssen, Kluger, & Ferris, 1994), MMSE (Crum et al., 1993; Folstein, Robins, & Helzner, 1983), Disability Assessment for Dementia (DAD) (Feldman et al., 2001; Gelinas, Gauthier, McIntyre, & Gauthier, 1999), and the Neuropsychiatric
Inventory (NPI) (Cummings et al., 1994). Given that participants in this study were diagnosed with mild to moderate dementia, post move data were collected in this 6 – 8 week period to avoid assessing changes that may be related to the natural progression of the disease.

The GDS is a brief, reliable clinical rating of the severity of dementia with a scale from 1 (asymptomatic) to 7 (late dementia) (Auer & Reisberg, 1997; Paul et al., 2002; Reisberg, Ferris, Leon, & Crook, 1982; Reisberg, Sclan, Franssen, Kluger, & Ferris, 1994). The GDS provides a multidimensional rating of cognitive, functional and behavioral symptoms collated into an overall staging of severity (Feldman & Woodward, 2005). Global measures provide valuable clinical information for ongoing assessment; however, such measures lack sensitivity to smaller changes (Feldman & Woodward, 2005). As a result, additional measures were used to specifically evaluate cognition, function and behavior to compensate for the limitations of the GDS.

The MMSE was used to assess cognition; this instrument consists of 22 questions that can reliably screen and assess changes in cognitive abilities in the elderly (Crum et al., 1993; Folstein, Robins, & Helzner, 1983). The MMSE is widely used in NL as part of the application process for LTC and supportive services. Total possible score is 30 with lower scores indicative of more cognitive impairment.

Function was measured using the DAD (Feldman et al., 2001; Gelinas et al., 1999). The DAD is a validated instrument that includes 23 instrumental activities of daily living and 17 basic activities of daily living based on caregiver ratings. The score is expressed as a percentage with lower scores indicating greater functional impairment.

The NPI was used to assess presence or absence of behavior disturbances (Cummings et al., 1994). The NPI is a reliable and valid tool used to assess a wide range of behaviors and their frequency and severity in individuals with dementia on the basis of information provided by the caregiver.

DATA ANALYSIS

All data were entered into Statistical Package for Social Sciences (SPSS, version 18.0, 2009). Basic descriptive statistics were used to analyze the demographic variables of the 41 residents. Tests of differences were used to determine whether any significant changes occurred in any area of functioning following the relocation of the residents to the PCRs. The Wilcoxon rank sum test was used to determine whether any change occurred in the resident's functioning within 6 to 8 weeks after relocation to the PCRs. The McNemar test of difference was used to determine whether any change occurred in the resident's behaviors within 6-8 weeks post relocation.

RESULTS

Of the 41 residents who relocated to the PCRs during the first year of operation, all but three were females. The mean age of the group was 82.87 years with a range of 54 to 97 years. Table 1 depicts the areas from which the residents were relocated and their current status. The majority of the residents (53.7%) who were relocated came from private or personal care homes. The remaining residents (46.3%) were relocated from either LTC (including a dementia care unit) or acute care.

<table>
<thead>
<tr>
<th>Variable</th>
<th>n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relocated From:</td>
<td></td>
</tr>
<tr>
<td>• Private Homes</td>
<td>15(36.6)</td>
</tr>
<tr>
<td>• Personal Care Homes</td>
<td>7(17.1)</td>
</tr>
<tr>
<td>• Acute Care</td>
<td>10(24.4)</td>
</tr>
<tr>
<td>• Long Term Care</td>
<td>9(21.9)</td>
</tr>
<tr>
<td>Current Status As of May 1, 2010</td>
<td></td>
</tr>
<tr>
<td>• Currently a Resident of PCR</td>
<td>24(58.5)</td>
</tr>
<tr>
<td>• Discharged Still Alive</td>
<td>10(24.4)</td>
</tr>
<tr>
<td>• Discharged but Deceased Later</td>
<td>5(12.2)</td>
</tr>
<tr>
<td>• Deceased as Resident of PCR</td>
<td>2(4.9)</td>
</tr>
</tbody>
</table>

Table 1 Demographics of Initial Residents Admitted to PCR (N = 41)
Table 2 depicts the mean score and the Wilcoxon rank sum test of differences for the MMSE, GDS and DAD which were used to assess level of functioning pre and post relocation. The mean score of the MMSE (N=26) and the GDS (N=35) revealed a slight decline in functioning; however, these differences were not statistically significant (See Table 2). In contrast and although not statistically significant, the mean score on the DAD (N=33) had increased marginally (from 74.24% to 77.79%) within 6 - 8 weeks after relocation to the PCRs. This suggests the group of residents demonstrated an improvement in their ability to perform instrumental and basic ADL.

The NPI assessed whether the residents experienced any changes in twelve behaviors after relocation. Table 3 illustrates the percentage of residents who experienced each behavior prior to and after the relocation. Although not statistically significant, there was a clinically significant change in that a number of residents experienced a decrease in the number of behaviors including delusions, agitation/aggression, anxiety, depression/dysphoria, and irritability/lability (See Table 3).

### Table 2 Resident Functioning Pre and Post Relocation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre Relocation M(SD)</th>
<th>Post Relocation M(SD)</th>
<th>Z Score</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMSE (N=26)</td>
<td>17.71(3.35)</td>
<td>16.57(4.56)</td>
<td>-1.336</td>
<td>.18</td>
</tr>
<tr>
<td>GDS (N=35)</td>
<td>3.37(.62)</td>
<td>3.46(.74)</td>
<td>-.775</td>
<td>.44</td>
</tr>
<tr>
<td>DAD (N=33)</td>
<td>74.24(11.53)</td>
<td>77.79(21.09)</td>
<td>-1.501</td>
<td>.13</td>
</tr>
</tbody>
</table>

### Table 3 Neuropsychiatric Inventory Questionnaire Pre and Post Relocation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Paired Samples*</th>
<th>Pre N(%)</th>
<th>Post N(%)</th>
<th>Pre N(%)</th>
<th>Post N(%)</th>
<th>McNemar Test p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delusions</td>
<td>35</td>
<td>10(28.6)</td>
<td>5(14.3)</td>
<td>25(71.4)</td>
<td>30(85.7)</td>
<td>.125</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>35</td>
<td>5(14.3)</td>
<td>5(14.3)</td>
<td>30(85.7)</td>
<td>30(85.7)</td>
<td>1.000</td>
</tr>
<tr>
<td>Agitation/Aggression</td>
<td>35</td>
<td>11(31.4)</td>
<td>10(28.6)</td>
<td>24(68.6)</td>
<td>25(71.4)</td>
<td>1.000</td>
</tr>
<tr>
<td>Depression/Dysphoria</td>
<td>35</td>
<td>9(25.7)</td>
<td>6(17.1)</td>
<td>26(74.3)</td>
<td>29(82.9)</td>
<td>.549</td>
</tr>
<tr>
<td>Anxiety</td>
<td>33</td>
<td>6(17.1)</td>
<td>4(12.1)</td>
<td>27(81.8)</td>
<td>29(87.9)</td>
<td>.727</td>
</tr>
<tr>
<td>Elation/Euphoria</td>
<td>35</td>
<td>0(0)</td>
<td>0(0)</td>
<td>35(100)</td>
<td>35(100)</td>
<td>N/A</td>
</tr>
<tr>
<td>Apathy/indifference</td>
<td>35</td>
<td>1(2.9)</td>
<td>2(5.7)</td>
<td>34(97.1)</td>
<td>33(94.3)</td>
<td>1.000</td>
</tr>
<tr>
<td>Disinhibition</td>
<td>35</td>
<td>1(2.9)</td>
<td>2(5.7)</td>
<td>34(97.1)</td>
<td>33(94.3)</td>
<td>1.000</td>
</tr>
<tr>
<td>Irritability/Lability</td>
<td>35</td>
<td>6(17.1)</td>
<td>5(14.3)</td>
<td>29(82.9)</td>
<td>30(85.7)</td>
<td>1.000</td>
</tr>
<tr>
<td>Motor Disturbance</td>
<td>35</td>
<td>1(2.9)</td>
<td>4(11.4)</td>
<td>34(97.1)</td>
<td>31(88.6)</td>
<td>.375</td>
</tr>
<tr>
<td>Nighttime Behaviors</td>
<td>35</td>
<td>4(11.1)</td>
<td>3(8.6)</td>
<td>31(88.6)</td>
<td>32(91.4)</td>
<td>1.000</td>
</tr>
<tr>
<td>Appetite/Eating</td>
<td>33</td>
<td>2(5.7)</td>
<td>0(0)</td>
<td>31(93.9)</td>
<td>33(97.1)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* N varies based on missing data
DISCUSSION

Although a significant amount of research has been conducted on relocation of elderly adults from one environment to another, very limited research has been conducted examining the relocation of individuals from private or personal home or institution to an assisted living environment. Limited Canadian research has been conducted on assisted living models for individuals with dementia. Significant research has been conducted on factors necessary for quality dementia care. Therefore, we have made comparisons to evidence that best reflect the model of care in this study or to relocation of individuals with dementia to a similarly described environment.

Although not statistically significant, participants in the current study were found to have a slight decline in cognitive functioning 6 - 8 weeks after admission to the PCRs as indicated by the mean score of the MMSE and the GDS. No comparable research was found to support these findings. The slight deterioration related to cognition and severity of dementia may be the result of small sample size post relocation as several residents were unwilling to respond to the MMSE.

Despite the slight decline in cognitive functioning, participants in the current study were found to have improvements in ADL and less confusion, anxiety and agitation. Similar to these findings, Hutchings et al. (2011) reported that family members perceived their loved ones to have less confusion and aggression and improved memory following relocation to the PCRs. Family members also reported an increase in their loved ones’ participation in social and recreational activities. Similarly, Roberts et al. (2000) reported improved outcomes of reduction in mental confusion, increased activity participation, and a higher level ADL functioning in individuals with dementia residing in congregate/group living/assisted living models in Sweden when compared to a control group residing in traditional institutional care. A cost utility study conducted by Wimo et al. (1995) demonstrated that group living clients experienced significantly slower deterioration in ADLs when compared to others in alternate living environments. Finally, MacCourt (2008) reported a higher level of function in residents who lived in licensed dementia housing when compared to those who moved to complex care. These findings were consistent with the increased level of functioning of residents in the current study.

The decrease in the percentage of residents exhibiting negative behaviours and the marginal increase in the residents’ functional abilities found in this study, although not statistically significant, is clinically important. The majority of our sample was admitted to the PCRs from a LTC or acute care environment; neither of these physical environments had private bedrooms and shared spaces such as those found in the PCRs. It is possible that the improvements in behaviour and function in this study were influenced by the physical design, participation in normal activities of daily living such as cooking, the availability of additional recreational activities and the type of staffing. The literature supports a small number of individuals residing in a home-like setting with private bedrooms, shared common kitchens, dining and living areas, and access to the outdoors as positive physical environmental features for individuals with dementia (Day et al., 2000; Hutchings et al., 2011). Additionally, the creation of a home-like environment and participation in organized activities positively affects the behaviour and mood of cognitively impaired residents (Annerstedt, Gustafson, & Nilsson, 1993; Cohen-Mansfield & Werner, 1998). Some studies have documented that individuals residing in group living or assisted living have a much slower decline in functional abilities at one to three years post admission when compared to those in institutional settings (Annerstedt, 1997; Wimo et al., 1995).

A psychosocial model emphasizing choice and promoting the use of functional abilities through purposeful activities and social interactions is recognized as being equally important as the physical environment (Chappell & Reid, 2000; Werezak & Morgan, 2003). While participation in recreation was not measured in the current study, families reported their loved ones had an increased involvement in social and recreational activities following relocation to the PCRs (Hutchings et al., 2011).

LIMITATIONS

The generalizability of the findings in this study is limited due to the small sample size. The sample size was significantly impacted by the fact that post testing was not completed for all those who completed pretests as some residents were unwilling to respond to the questions required by the MMSE. It is possible that the short length of time between pre and post tests (i.e., 6-8 weeks) may have reduced the likelihood of detecting statistically significant changes in function, cognition and behaviors. A decision was made to conduct the post test at 6 - 8 weeks to avoid assessing changes that may have been related to natural progression of the disease. Finally, many of those who relocated to the PCRs experienced mild to moderate severity of dementia according to GDS scores. It is possible that the findings do not fully represent individuals with moderate dementia.
IMPLICATIONS

This study has several implications for policy direction. The design of the PCRs provides the groundwork for future program planning for living spaces for individuals with dementia. In the period following the opening of the first three PCRs, it was determined that there was a population of individuals with more advanced levels of dementia who required a higher level of dementia care and a different staffing model. This information should provide guidance to administrators and government officials when planning strategic directions for dementia care in NL.

From a clinical practice perspective, the findings from both this study and the research suggest that developing and maintaining specific dementia care programs is essential to enhancing the quality of life and functional ability of residents with dementia. It is crucial that administrators and government officials ensure that resources and infrastructure are available at all phases of program development, implementation and ongoing evaluation.

The overall care philosophy in the PCRs is described as one that focuses on quality of life and finding purpose in daily activities rather than on physiologic rehabilitation and “cure”. Welsh, Moore, and Getzal (2012) support this philosophy of care. It incorporates the belief that cognitively impaired clients function best in a smaller, home-like unstructured environment with individuals with similar needs. The focus is on residents, their needs and their normal living experiences while providing 24-hour supervision.

The findings from this study demonstrate that relocation to an appropriate enhanced assisted living environment for individuals with mild to moderate dementia will not result in negative impacts on function, cognition, or behaviour within 8 weeks post relocation. There is evidence to suggest that participation and involvement in normal daily activities may have a positive impact on overall function of individuals with mild to moderate dementia. The findings support that an appropriate program for individuals with mild to moderate dementia can be delivered by a skill mix which includes unregulated workers with clinical supervision and support.

As the majority of the population in this study experienced mild cognitive impairment, comparing outcomes of those with more moderate cognitive impairment may be beneficial. Additionally, further research is required to determine what level of dementia is best supported in an enhanced assisted living environment and what characteristics best predict successful relocation and continued stay.

FUNDING

Kelli O’Brien was a recipient of the Canadian Health Services Research Foundation’s Executive Training for Research Fellowship, and this research was completed in partial fulfillment of this program. This work was also supported by the Western Regional Health Authority, Western Regional School of Nursing, and the Grenfell Campus, Memorial University of Newfoundland.

Acknowledgments

Special thanks to Nicole Pollett, Social Worker at PCRs, and Trudy Read, Manager of PCRs at the time of the study, for their support and assistance during the study period.

REFERENCES


SCOPEOUT: SUSTAINABILITY AND SPREAD OF QUALITY IMPROVEMENT ACTIVITIES: A FOLLOW-UP TO A PILOT STUDY

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BACKGROUND

SCOPEOUT is a one year follow-up study that examined if and how the improvements and activities achieved in the SCOPE pilot study were continued and spread throughout the facility after the study ended. SCOPE (Safer Care for Older Persons [in residential] Environments), was a two year (2010-2012) pilot study, conducted in 10 long-term care units within seven long-term residential care facilities (i.e., nursing homes) in Alberta and the Interior Health region of British Columbia, that used care aide led quality improvement teams to implement a care improvement intervention (Cranley et al., 2011, 2012; Norton et al., 2013). Staff participating in the intervention formed ten local quality improvement teams to implement strategies for improving one of three areas of resident care: pain/discomfort management, management of dementia-related behaviours, or skin care/pressure ulcer prevention and management (Cranley et al., 2012). The SCOPE study was successful in that it empowered and motivated care aides to learn to make a change within their nursing home unit (Norton et al., 2013).

APPROACH

We conducted quarterly surveys with nurses, care aides, and allied health professionals over 18 months (5 time points) within the seven nursing homes to determine the extent to which SCOPE study activities were still in place or to which new quality improvement activities had been introduced. We also interviewed facility managers twice over the study period.

HIGHLIGHTS OF THE FINDINGS

We have recently completed our data collection. We received over 700 surveys and interviewed the seven facility managers. Findings are summarized below:

- Quality improvement activity across the intervention units was sustained over the period of the follow-up study.
- There was little spread of quality improvement activities to non-intervention units within the same facility.
- Quality improvement activity was being promoted across the facilities during the project and may have had some impact.
- There is an ongoing need for active leadership support for teams to provide motivation to sustain and spread gains achieved through initial work.

IMPLICATIONS FOR PRACTICE AND POLICY

Sustaining improvements in care quality has important implications for practice and health care systems. Sustaining initial enthusiasm for a new intervention is difficult and requires continued attention at both the unit and leadership level. Intervention “boosters” which vary in nature (to keep interest) are likely to be required to sustain quality improvement activities after the initial project has ended. Strong leadership support from administrators and managers to teams is a key requirement for creating sustainable quality improvement activities within long-term residential care settings. In turn, these activities may become embedded into routine care. Long-term residential care settings have largely unregulated care aides working as staff to provide care. As a result they are a promising group to work with in changing practice. The engagement and empowerment of this group may comprise a solution to the many challenges of caring for older adults in this setting. The necessary infrastructure (e.g., human resources) to sustain such activities is poorly developed in long-term residential care settings. The infrastructure is important in achieving meaningful, sustainable quality improvement. We need to develop effective interventions and sustainable infrastructures that can support quality improvement activities designed to improve the quality of care delivery to older Canadians residing in long-term residential care settings.
This study was funded by Dr. Wagg’s endowed research chair in geriatric medicine.

REFERENCES


As the Canadian demographic is getting older, hospitals across Canada are looking for ways to best serve an aging population. In Sudbury, Ontario, at Health Sciences North (HSN) we are engaging with our community and using several strategies to enhance services and ensure that we are meeting the particular health needs of seniors and their families not only in Sudbury but across Northeastern Ontario. HSN is the largest multi-site hospital in Northern Ontario, with 450 beds and it is considered to be a regional leader in high quality patient care, research and education. Improving senior’s health has become a major priority at HSN and we are working to develop strategies to promote community engagement. One of the ways we have approached this is through a series of public forums entitled “HSN Seniors’ Summits: Designing a More Seniors-Friendly Community.” HSN engages with nurses, allied health professionals, and clients to showcase different programs and services available to our seniors in Sudbury. The summits are free and open to health care professionals as well as members of the community and are headlined by a panel of expert speakers, followed by a question and answer session. This type of public engagement is a key part of HSN’s mandate to promote health in our community for older adults and create important dialogue. Questions explored at the summits include: “How do you make the health care system work better for seniors whether they are at home or in the hospital?” and “What roles can patients and their families play in improving the system?” These summits discuss available programs as they pertain to the health of seniors and show how services can promote better client outcomes.

The summits begin with seniors sharing the story of their hospital experiences and community issues. Esmonde Crawley, International Editor-in-Chief, Over 50s Housing Weekly News (reviews new trends on seniors housing), was the keynote speaker at the first summit and addressed global seniors’ housing. The second summit keynote speaker, Sholom Glouberman, President, Patients’ Association Canada spoke about now being the time for providers to do things with patients and their families to ensure the greatest health experience possible. The third summit featured a presentation from David McNeil, HSN’s Vice President of Clinical Programs and Chief Nursing Officer about HSN’s ongoing efforts to be more senior-friendly in its care. McNeil also leads the development of HSN’s own Seniors Strategy to ensure new programs deliver efficacious health care to seniors during and after their stay in hospital.

This past January we held a summit on the end-of-life journey and care, which included options such as palliative care, hospice care, hospital-based care, and in-home end of life care. The evening’s two keynote speakers were Dr. Brian Goldman, ER physician at Mount Sinai Hospital in Toronto and host of the national CBC radio program “White Coat, Black Art” and Dr. Harvey Chochinov, Distinguished Professor of Psychiatry at the University of Manitoba, Director of the Manitoba Palliative Care Research Unit at Cancer Care Manitoba, and the holder of the only Canada Research Chair in Palliative Care.

These summits have served as “conversation starters” in our community with more than 600 participants taking part in the evening events. In fact, all four summits have led to a better understanding by the public about not only the challenges surrounding care of seniors in our city, but also the steps and innovations that are being developed to help them as they get older.

HSN is also implementing new programs and policies to ensure that seniors are benefiting from the latest research and understanding into care for seniors. One of the key challenges for many seniors is transitioning back home after a stay in the hospital. While they might be over their acute episode, they still might not be fully up to coping at home. That is why at HSN, through a close partnership with our local Community Care Access Centre (CCAC), launched the Short Term Assessment and Treatment (STAT) clinic. The main goals of STAT are to preserve the health of frail seniors, to allow them to continue to live in their home and in their community, and to prevent their health from deteriorating to the point where they must be admitted to hospital. Together, a multidisciplinary STAT treatment team develops an individualized care plan based on common health factors for seniors such as medication management, mobility/balance challenges, chronic pain, and caregiver burden/burnout to mention a few.

At HSN, we see research as key to improving the
health of seniors. Together with our research affiliate, the Advanced Medical Research Institute of Canada (AMRIC), under the direction of Dr. Francisco Diaz-Mitoma (CEO), we have been conducting into program evaluation research to address the current and future needs of seniors. Researchers are working alongside with nurses and geriatricians at HSN to transform the care of seniors, to prevent unnecessary hospitalizations. Not only is hospitalizing elderly patients costly to the health care system, it can rob the older adult of months, if not years, of their lives. Led by Dr. Janet McElhaney, Medical Lead for Seniors’ Care at HSN, and Senior Scientist at AMRIC, researchers are looking at how to prevent frailty through a program dubbed “48/5”. Under this initiative, care of the older patients starts within 48 hours of hospital admission addressing five key areas: delirium, medications, nutrition and hydration, bowel and bladder issues, and functional mobility. Addressing these five key factors early helps reduce the chances of older patients becoming frail and requiring longer hospitalization or being transferred into a long term care facility.

In 2012, HSN President and CEO Dr. Dennis Roy established the CEO Patient and Family Advisory Council (PFAC) to engage former patients and family members as partners in the design and redesign of services at HSN. Council members provide advice to the CEO and leadership on matters relating to patient-provider relationships, safety, quality improvement and patient education as well as other issues relevant to patient care. Dr. Roy was inspired to create this new hospital council because of a quote he read “No decision about me... without me” by British Prime Minister David Cameron. To ensure HSN isn’t making decisions affecting patients without consulting them, there are 14 patient advisors on the PFAC, who work alongside five senior management hospital staff and the CEO. Instead of just being a forum to voice dissatisfaction, Dr. Roy requests input from council members on how to improve the patient experience at HSN. In this way, patient advisors are able to provide direct input into the decision-making process. This ensures that HSN takes into account the views of those for whom we care.

While this patient and family council is a new idea for Sudbury, it has been implemented in other health care institutions across Canada, including the Saskatoon Health Authority. Council members reflect the region’s cultural diversity and work in the spirit of partnership with the hospital. The PFAC meets six times a year, and each member serves a two-year term. The CEO keeps the hospital board of directors informed of the council’s activities and undertakings. Since established, the PFAC has provoked some profound changes at HSN. One has been the adaptation of the Name, Occupation and Duty (NOD) initiative, when interacting with patients and families. Communication between healthcare providers and patients is important for the safety of patients, as well as for reducing patient anxiety and stress. NOD involves staff stating their Name, Occupation and Duty when interacting with patients and families. It is a simple communication tool that all members of the healthcare team can use (clinical and non-clinical) to enhance the patient experience at HSN.

In conclusion, for HSN, several strategies have been implemented to enhance and improve services to seniors though community engagement. Any or all of these strategies might be useful in other regions of Canada. Outreach strategies like the HSN Seniors’ Summits, partnerships like the Short Term Assessment Clinic, and in-hospital programs like the “48/5”, the Patient and Family Advisory Council and the Name, Occupation and Duty initiative have the potential to engage the community and enhance the health and wellbeing of the seniors.