



Coming together and pulling apart: Exploring the influence of functional status on co-resident relationships in assisted living



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ABSTRACT

Social relationships can have considerable influence on physical and mental well-being in later life, particularly for those in long-term care settings such as assisted living (AL). Research set in AL suggests that other residents are among the most available social contacts and that co-resident relationships can affect life satisfaction, quality of life, and well-being. Functional status is a major factor influencing relationships, yet AL research has not studied in-depth or systematically considered the role it plays in residents' relationships. This study examines the influences of physical and mental function on co-resident relationships in AL and identifies the factors shaping the influence of functional status. We present an analysis of qualitative data collected over a one-year period in two distinct AL settings. Data collection included: participant observation, informal interviews, and formal in-depth interviews with staff, residents, administrators and visitors, as well as surveys with residents. Grounded theory methods guided our data collection and analysis. Our analysis identified the core category, "coming together and pulling apart", which signifies that functional status is multi-directional, fluid, and operates in different ways in various situations and across time. Key facility- (e.g., admission and retention practices, staff intervention) and resident-level (e.g., personal and situational characteristics) factors shape the influence of functional status on co-resident relationships. Based on our findings, we suggest strategies for promoting positive relationships among residents in AL, including the need to educate staff, families, and residents.

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Introduction

There is a well-established relationship between age and functional disability (Lewis & Bottomley, 2008a, 2008b). Consequently, greater life expectancy and the rapid aging of

the population will result in increasing numbers of individuals with functional limitations. Many older adults will reach a point when they are no longer able to perform activities of daily living (ADLs) or live independently and some will require formal long-term care (LTC), including assisted living (AL). Theoretically, AL is based on a social model of care, which means it provides a home like environment and also promotes the principles of autonomy, privacy, and freedom of choice among residents (Carder, 2002), but in practice these principles are not followed universally by residents

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and workers in various AL settings (Roth & Eckert, 2011). Typically, AL settings provide watchful oversight, assistance with ADLs, and certain instrumental activities of daily living (IADLs) (e.g., medication management, meal preparation, and household cleaning) (Ball et al., 2000; Burdick et al., 2005).

In the United States, nearly one million individuals reside in AL settings and the number is expected to grow (Golant, 2008). Most AL residents are female, over 85 years old (Caffrey et al., 2012), require assistance with approximately two ADLs (National Center on Assisted Living, 2009), and are without a partner or spouse (Centers for Disease Control (CDC), 2010). Nearly half of the AL population has Alzheimer's disease or another type of dementia and other chronic diseases also are prevalent, including high blood pressure, heart disease, depression, arthritis, osteoporosis, diabetes, COPD and related conditions, stroke, and cancer (Caffrey et al., 2012). These mental and physical conditions can affect an individual's functional status, which influences social encounters and relationships (Iecovich & Ran, 2006).

When older adults move to AL, many maintain pre-existing social relationships with family, friends, and neighbors (Yamaski & Sharf, 2011), and some form new, sometimes meaningful, relationships with others (see for example, Ball et al., 2005; Eckert, Carder, Morgan, Frankowski, & Roth, 2009). AL residents have three main types of social relationships, including those with: (a) friends and family outside AL; (b) co-residents; and (c) paid caregivers (Ball et al., 2000; Burge & Street, 2010; Perkins, Ball, Kemp, & Hollingsworth, 2013; Tompkins, Ihara, Cusick, & Park, 2012). Family connections are very important for residents but, for the majority, family members are not available daily (Ball et al., 2005, 2000; Gaugler, 2007). Relationships with staff also carry importance (Ball et al., 2005; Ball, Perkins, Whittington, Hollingsworth, & King, 2009), but quite often staff members do not have adequate time to socialize with residents beyond their care-related interactions (Ball et al., 2009; Kemp, Ball, Hollingsworth, & Lepore, 2009). Residents' relationships with other residents in AL can be of considerable importance in their lives and are predictors of life satisfaction or subjective well-being (Park, 2009; Perkins, Ball, Kemp, & Hollingsworth, 2013) and quality of life (Ball et al., 2005, 2000; Burge & Street, 2010; Street & Burge, 2012; Street, Burge, Quadagno, & Barrett, 2007). Previous qualitative research by Kemp, Ball, Hollingsworth, and Perkins (2012) indicates that co-resident relationships in AL can range from strangers to friends and include enemies and romantic type relationships with each resident experiencing a unique "social career" (i.e. their combined set of co-resident relationships and social trajectory in AL). This analysis identified a number of multi-level factors influencing co-resident relationships, including facility location and community connections, staff training and knowledge of residents, and resident tenure, gender, marital status, family involvement, and functional status. Residents' functional status was a major individual-level factor influencing co-resident relationships. Functional impairment acted as a double-edged sword in that it promoted interactions through less impaired residents helping those with greater impairment, but it also hindered relationships because of such barriers as frequent medical appointments, decreased mobility, and communication problems.

AL residents often attach meaning to their relationships with those who are functionally similar (Ball et al., 2005; Perkins, Ball, Whittington, & Hollingsworth, 2012). For example, residents with dementia may repetitively talk to each other without consequence (Ball et al., 2005) and sometimes they develop friendships (de Medeiros, Saunders, Doyle, Mosby, & Haitsma, 2012; Doyle, de Medeiros, & Saunders, 2012). However, residents without dementia may not be tolerant of those with dementia, choosing to distance themselves, and in some instances form cliques based on functional status (Perkins et al., 2012; Roth & Eckert, 2011). Stigma often is attached to both physical and cognitive impairments in AL, which further impedes interactions and relationships among residents of varying functional abilities (Dobbs et al., 2008; Hrybyk et al., 2012; Perkins et al., 2012; Shippee, 2009).

Certain facility and resident factors are apt to shape the influence of functional status on co-resident relationships in AL. For instance, Doyle et al.'s (2012) study involving AL residents in an all-dementia care setting found environmental and organizational barriers to intergroup interactions. Locked doors represented an environmental barrier. Meanwhile, organizational factors related to staff preferences in completing tasks, included, for example, taking residents to their room after meals rather than providing opportunities to interact with each other (see also, Kemp et al., 2012).

Iecovich and Ran (2006) examined the inclination of healthy older adults to form relationships with older adults suffering from disability in two settings: one where those of differing functional statuses were integrated and another where they were segregated. Healthy older adults in the integrated facility tended to develop more negative attitudes toward their disabled peers compared to those living separately. One interpretation of this finding is that functionally-able older adults relate to others' disabilities as possible outcomes of their own future, which could ultimately lead to death. Being fearful from this perspective would mean avoidance and suggests that individual attitudes and beliefs are apt to influence relationships. Other research indicates that some residents' personal preferences may play a role, as some with poor functional status desire privacy, do not want to be bothered by others, and prefer to spend most of the time in their rooms (Ball et al., 2005; Perkins et al., 2012; Roth & Eckert, 2011).

Although existing research highlights the importance of co-resident relationships in AL, hinting at the complex influence of cognitive and physical functioning, research has yet to provide an in-depth understanding of how functional status affects these peer connections. Our present analysis seeks to: (a) understand how functional status influences co-resident interactions and relationships; and (b) identify the factors that shape how functional status affects social interactions and relationships. Addressing these aims will contribute to the development of strategies for promoting positive social experiences in AL and improving resident quality of life.

Design and methods

We draw on data from the mixed-methods study, "Negotiating Residents' Relationships in AL: The Experience of

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