Relocating a Nursing Home

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ABSTRACT
One of the areas that is included in facility management is relocation and move management. This exploratory research focuses on the relocation of nursing home residents and the influence on their wellbeing. As other organizations, nursing homes do change over time. Such changes may include reorganizations, mergers, and closures.

At the same time such changes will foster a changing demand for space. As a direct consequence there may be a need to relocate residents leading to transitional and irreversible spatial interventions in the life of these nursing home residents. This may affect their physiological and psychological wellbeing: be reminded that a relocation process may cause serious stress and related health problems at these residents.

The aim of this paper is to provide a literature review of studies on relocation outcomes. Because no recent literature was found on the particular Dutch situation, other studies have been reviewed in order to expose the diversity of studies and varying results.

It is confirmed that relocation influences the wellbeing of nursing home residents. Positive or negative influences are determined by the organization of the relocation. Positive influences can be expected, for instance, if residents are mentally well-prepared prior to the move, if extra staff is deployed to stay in close contact with residents during the move, and if facility managers develop after-care programs until residents are completely accustomed to the new situation.

Keywords
Elderly, Facility Management, Moving, Nursing Homes, Relocation, Wellbeing

1 INTRODUCTION

In 2011, The Netherlands counted 16.7 million citizens of which 2,594,946 (15.6%) citizens are 65 years or older. 667,547 (4%) of these citizens are older than 80 years. In 2011, approximately 160,000 elderly are living in a Dutch care or nursing home (Health Care Inspectorate, 2012): a total of 6.2% of those older than 65 and 1% of the total Dutch population.

The proportion of the population in the age of 65 years and older is rising significantly: from 6% in 1900 to 15.6% in 2011 and towards a predicted 25.9% in 2040 (Statistics Netherlands, 2012). These changing demographics are very likely to increase demand for care and put, together with government savings, the Dutch health care system under pressure.

2 HEALTH CARE IN THE NETHERLANDS

The Netherlands have a dual-level healthcare system which means that all primary and curative care is financed from private obligatory insurance. This covers for example the cost of a physician, a hospital, and pharmacy. The companies that offer the private insurances must offer a core universal insurance package at fixed prices. This package covers the primary curative care. Besides these core packages, insurance companies can offer additional services at extra cost.

Long term care for the elderly and, for instance, for long term mentally ill people is covered by social insurance funded from taxation. The 'General Law on Exceptional Medical Expenses', in The Netherlands known as the AWBZ, is a Dutch health care law which provides general insurance for special health care needs. This AWBZ is intended for 'care' rather than 'cure'. In the Netherlands, more than 600,000 people are supported by this law. On the basis of a care needs assessment the authority decides to what degree a person gets compensation from the AWBZ. Through this legislation, the AWBZ will (partially) pay for nursing home costs. This nursing can either be extramural care (at home) or residential care (in a residential). The lowest care needs package required to get residential care paid by the AWBZ is the so-called package nº4.

Of the ten care needs packages, nº4 is the package that contains sheltered housing with intensive support and extended care. Lower packages also contain *sheltered* housing, but with less needs for support and care, whereas higher packages contain *protected* housing and intensive or very intensive care. These higher care needs packages are assigned to people who suffer from severe dementia (nº5), a chronically physical disease (nº6), psychiatric problems in combination with physical problems or brain damage (nº7) and people with a severe physical disease and therefore with a very special need of care (nº8). The highest packages are assigned to people who need temporary care after major surgery (due to physical disease, nº9) or to people who are terminally ill (nº10).

2.1 Changes in Dutch Legislation

On 29 October 2012 the winning parties of the Dutch elections concluded a coalition agreement. In this agreement, the governance announces that patients with less demanding needs will receive care at home rather than residential care. In this way, they aim to separate accommodation and care. It means that the elderly will no longer be entitled to care needs package nº4 or care needs packages of a similar level. The measure will apply to new clients and re-assessments as from 2016.

In addition, from 2017 home care will be transferred from the Exceptional Medical Expenses Act (AWBZ) to the Healthcare Insurance Act (ZVW), placing it in the same system of population-based funding as general practitioners care, and will be subject to a care needs assessment (Government of the Netherlands, 2012).

This change in funding – as well as the separation of living and care – will affect the way nursing homes are organized and are therefore motives to change.

2.2 Nursing Homes Changes

The developments aforementioned make it necessary to change the organization of nursing homes. These changes include for example reorganizations, mergers, and closures (Castle, 2001) and may be organizational, architectural, or both. Most likely it will affect the organization as such and the spatial environment in which it operates through what a changing demand for space will emerge. This can result in a need to relocate.

3 FACILITATING THE RELOCATION

One of the areas that is included in facility management is relocation and move management (Barrett & Baldry, 2003; Cotts et al., 2010). A facilities manager should carefully plan and co-ordinate all elements of the relocation. He should also keep clients informed at all stages of the process (Wiggins, 2010).

Relocation is defined as 'moving from one environment to another for various reasons' (Burnette, 1986). Relocation is a change in physical and social environment (Young, 1990). However, relocation involves not only the actual physical relocation but also the adjustment to new surroundings afterwards (Johnson & Hlava, 1994).

3.1 Organization, Space and Health

Mobach (2009) states that the spatial environment influences health, mind and behaviour of people. Research also shows that the physical healthcare environment affects the wellbeing of patients (Dijkstra et al., 2006). Joseph confirms this as she concludes that the design of the physical environment impacts resident outcomes in long-term care settings and contributes to a better quality of life for those who live in these facilities (2006). Relocation leads to transitional and irreversible change of the spatial, organizational and social environment of nursing home residents.

3.2 Relocation Outcomes

Relocation events may be detrimental to the wellbeing of the nursing home residents: potential negative outcomes are mortality, physiological decline and psychological decline (Castle, 2001; Castle, 2005; Jolley et al., 2011). In addition, relocation can change cognitive performance and social engagement and it can also lead to depression (Castle, 2005).

Reviews of relocation literature show varying results. In some studies, mortality is higher after relocation but in other studies there were no significant findings or mortality was even lower after relocation (Castle, 2005; Davis et al., 1990; Thorson & Davis, 2000). The same holds for changes in health (physiologic or psychological): some studies found increase or decrease of health after relocation, while others had non-significant findings when examining the association between changes in health and relocation (Castle, 2001; Castle, 2005).

Castle (2001) performed a systematic review of 78 empirical studies addressing relocation of the elderly.[1] The review has confirmed the large variety of relocation outcomes. The outcomes of the reviewed relocation studies included mortality rates, morbidity, and psychological and social status. The results of these studies on patient outcomes: mortality, morbidity, and psychological and social status are presented in tables 1, 2, and 3 respectively. For each study, patient outcomes of the relocated groups were compared with expected patient outcomes based on the pre-relocation comparison groups. In the tables are the numbers of studies in which the outcomes of relocated residents were equivalent, higher or lower than expected. If both outcomes were the same it was equivalent to the expected outcome. In other situations, for instance, the outcome could be higher or lower in situations when the relocated groups had respective higher rates of mortality and lower rates of mortality compared to the expected outcomes based on the pre-relocation comparison groups.

Table 1 A comparison of studies on mortality rates at relocated and pre-relocation groups

Comparison **Outcome**	Number of studies in which mortality of relocated residents was *equivalent* to pre-relocation	Number of studies in which mortality of relocated residents was *higher* than at pre-relocation	Number of studies in which mortality of relocated residents was *lower* than at pre-relocation
Mortality Rate	49%	30%	21%

In almost half of the studies (49%) the mortality rate of the relocated residents was equivalent to the mortality rate at the pre-relocation comparison groups (table 1). Of the other half of the studies mortality was higher after the relocation than before. More specifically, the maximum mortality rate of the post-relocation groups was 7.5% higher than the maximum rate of the pre-relocation groups.

Table 2 A comparison of studies on morbidity at relocated and pre-relocation groups

Comparison **Outcome**	Number of studies in which morbidity of relocated residents was *equivalent* to pre-relocation	Number of studies in which morbidity of relocated residents was *higher* than at pre-relocation	Number of studies in which morbidity of relocated residents was *lower* than at pre-relocation
Morbidity	55%	39%	7%

More than half (55%) of the studies that researched morbidity show equivalent outcomes for the relocated and pre-relocation group (table 2). The other studies mainly showed higher morbidity outcomes for the relocated groups than at pre-relocation. This means that general health of the residents was poorer after the move than before.

[1] In his study, Castle (2001) compared 78 studies addressing the relocation of elderly. He analysed these studies on mortality, morbidity and psychological or social statuses and included in this review the research design, control variables, type (voluntary/involuntary) relocation, sample size, and facility setting.

Table 3 A comparison of studies on psychological and social statuses at relocated and pre-relocation groups

Comparison / **Outcome**	Number of studies in which psychological and social statuses of relocated residents was *equivalent* to pre-relocation	Number of studies in which psychological and social statuses of relocated residents was *higher* than at pre-relocation	Number of studies in which psychological and social statuses of relocated residents was *lower* than at pre-relocation
Psychological and social statuses			
Positive indicators	51%	27%	22%
Negative indicators	65%	22%	13%

In case of psychological and social statuses (table 3), a distinction has to be made between positive and negative indicators in order to give the right meaning to the patient outcomes. For the positive indicators it means that the higher the outcome, the better it is for the wellbeing of the residents (for example hygiene and life satisfaction). For the negative indicators it means that the higher the outcome, the worse is it for the wellbeing (for example violent behaviour and alienation). In both, more than half of the studies show unaltered psychological and social statuses of the relocated groups compared to the pre-relocation groups. Of the other half of the studies that researched on the positive indicators a slight majority shows an improved psychological and social status, whereas the studies on negative indicators show a decrease of wellbeing.

Relocation outcomes vary. While there are a few studies confirming positive patient outcomes, most studies show patient outcomes of relocated residents that were equivalent to the pre-relocation comparison groups. However, mortality and morbidity rates as well as the indicators of psychological and social statuses where the second highest. These are negative impacts on the wellbeing of the residents.

3.3 Reducing Negative Impact

Relocation effects may be positive when nursing home residents are prepared for the move: the choices the residents have directly impacted on their quality of life (Cohen, 1981; Holzapfel et al., 1992). There are practices that will reduce the stress and its possible consequences during pre-relocation, relocation and post-relocation phases (Jolley et al., 2011).

In the pre-relocation phase it is important to inform residents, make careful plans and facilitate discussions. In addition, it is also essential to undertake individual medical and psycho-social needs assessments and to arrange familiarization visits to the new facility (Castle, 2001; Jolley et al., 2011). Planned interventions may reduce negative impact. Pre-relocation involvement of the nursing home residents in visiting the new facility and in selecting their bedrooms and roommates reduced their anxiety to an acceptable, even positive level because this involvement makes the new environment more predictable (Holzapfel et al., 1992; Kowalski, 1981; Locker & Rublin, 1974). According to Keister (2006), predictability to the new environment was inversely related to anxiety. When people are prepared for the relocation, they give higher appraisal, higher morale, functional independence, and lower harm-loss scores (Gass et al., 1992; Petrou & Obenchain, 1987).

In facilitating the relocation itself, appropriate health checks (at departure and arrival) should be done, a familiar and responsible person should travel with the resident (Rosswurm, 1983) and each resident should get a warm welcome at the new facility in order to feel safe,

comfortable and wanted. The care providers better approach the relocation as a positive step or challenge and appeal to the residents' strengths and skills to avoid negative labels (Holzapfel et al., 1992; King et al., 1987). For relocating successfully, mastery (the belief that life is under one's control), social support, and cognitive appraisal (assigning meaning to the relocation event) of the older adults are important (Keister, 2006; Rantz & Egan, 1987).

Once the relocation is over, it is good to organize a review of progress and current health and psycho-social care needs in the post-relocation phase. It is also important to provide orientation within the new facility and to maximize stability and continuation of good practices from the previous home (Jolley et al., 2011).

Interventions that involve, inform, and prepare older people before relocation to enhance their sense of control and the predictability of the move might minimize adverse relocation effects (Falk et al., 2011; Johnson & Hlava, 1994). All nursing home residents are individuals which are not equally vulnerable to these adverse effects (Jolley et al., 2011; Keister, 2006; Holzapfel et al., 1992; Gass et al., 1992).

Table 4 shows three other studies from Amenta et al. (1984), Potter & Berger (1974) and Castle (1997) emphasizing key elements of facilitating relocation in order to reduce negative impact.

Table 4 How to Relocate a Nursing Home?

Amenta et al., 1984	**Potter & Berger, 1974**	**Castle, 1997**
1. To all residents, show a film describing the new facility	1. Let the staff describe the new facility to the residents	1. Ask residents what their preferences or choices for a new home are
2. Take residents several times to the new facility	2. Discuss rooms and roommates	2. Ask residents' family members for their facility preferences
3. Prior to the move, take inventories of personal possessions	3. Let residents handle their own property as much as possible	3. Let a committee review the preferences and choices of each resident (and their family)
4. Individual counselling of needs regarding the move	4. Give residents a tour around the new facility	
5. Let residents themselves choose roommates		

5 CONCLUSION

A facilities manager should carefully plan and co-ordinate all elements of the relocation (Wiggins, 2010). In moving a nursing home, the difficulty may lie in the fact that it has to be moved without closing it in the process (Denoyer, 2011). This literature review highlights the elements of the relocation which are important to plan and co-ordinate in order to reduce negative impact on the residents.

It can carefully be concluded that within a relocation process three phases can be distinguished. In the first *pre-relocation* phase, the facility manager has to ensure that the residents are prepared for the move. For this purpose, he has to consider which people are most suitable to take care of this preparation and how the preparation program should look. The second phase contains the *relocation process* itself. During this phase, the facility manager is mainly focused on the physical move and should therefore deploy staff that can stay close to the residents. For example, nurses who are known to the residents. When the relocation is over, the third *post-relocation* phase is about to begin. When this phase ends, varies by each relocated nursing home. The facility manager has to develop a kind of after-care program in which he includes monitoring the health of the relocated residents as well as remedying deficiencies in the new facility.

So, the responsibility of a facility manager should not only be to oversee the physical facilities and activities, but also to have a responsibility for taking care of the nursing home residents' wellbeing during the relocation process. Only in this way, the facility manager can potentially optimize a relocation process and reduce or eliminate potential negative impact on the wellbeing of the nursing home residents. This emphasizes the multidisciplinary nature of the field of facility management.

Further Research

Despite these findings, there is still a need for further research on the impact of relocations on old and cognitively impaired people, the research methods that should be used, and the effects of preparatory interventions (Falk et al., 2011).

A longitudinal comparative case study can be done to assess relocation appraisal and effects on the wellbeing of nursing home residents prior to the event of relocation and several times during one year following relocation in order to investigate changes in relocation appraisal and wellbeing over time (Gass et al., 1992). It may also be interesting to assess what kinds of preparation are most successful (Thorson & Davis, 2000) and how characteristics of the relocatees and the new facility influence the relocation outcomes (Castle, 2001). A challenge in this field of research is to increase validity and reliability by using control groups that are representative and that using such control groups is ethically responsible since it is about people's health.

Furthermore, no recent studies have been found that researched the relationship between relocation and wellbeing of nursing home residents in the Netherlands. For further research, one could consider examining this relationship in the Dutch context.

None of the studies explicitly examined the impact of the facility manager on the process and outcomes of the process. In the field of facility management, a study about this impact might be a valuable contribution to the literature and the profession of facility management.

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