

**Examining Transitions along the Continuum of Care for Older Adults in Retirement
Communities: Opportunities for Occupational Therapy**

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Author Note

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Abstract

A better understanding is needed of the transitions that older adults experience when moving to new environments and across levels of care. This doctoral capstone project aimed to create opportunities for occupational therapy practitioners to address older adult transitions in future practice. In preparation a needs assessment and literature review were completed to inform the development of project goals. Residents were interviewed using the Quality of Life and Well-Being through Transition Questionnaire, adapted from established tools. Analysis of the interviews guided the design and implementation of interventions with a focus on evidence-informed practice. Informed by existing literature, this project further explored older adults' experiences as they required additional care within a retirement community, offering insights into how transitions impact quality of life and well-being. The high socioeconomic status of residents at the site may have influenced their perceptions of quality of life, limiting generalizability to other retirement communities. Therefore, future studies would benefit from applying similar assessment tools across diverse retirement communities to further examine older adults' perceptions of quality of life, well-being, and their experiences during transitions to new settings.

Keywords: occupational therapy, transitions, older adults, quality of life, retirement communities

Examining Transitions along the Continuum of Care for Older Adults in Retirement Communities: Opportunities for Occupational Therapy

Between 2015 and 2050, the world's population of adults over 60 years of age is expected to nearly double (World Health Organization, 2022). Due to the growing rates of older adults across the world, communities have a growing need for senior residences and services. As older adults age, many move from living independently to assisted living (AL) facilities where they need some extra help with everyday activities. Others may need a short-term rehabilitation stay to recover from adverse health events prior to returning home. For older adults with more complex needs, many move from independent homes or AL to skilled nursing facilities. Each move between levels of care in the continuum is considered a transition. Many older adults who transition to higher levels of care experience a loss of independence and feelings of confusion, anxiety, and depression (Scheibl et al., 2019). This doctoral capstone (DC) project took place at Westminster Village, a retirement community in Tippecanoe County, Indiana, that offers living options across the continuum of care, including independent living (IL), AL, memory care, and skilled nursing services in the health center (Westminster Village, 2025).

Older adults often present with health conditions which have an impact on quality of life (QoL) and overall function (Toledano-González et al., 2019). Occupational therapy (OT) best practice anticipates that occupation-based and client-centered practices will be linked to improvement in QoL and occupational performance for older adults (Mitterfellner et al., 2024). This DC project seeks to illuminate the challenges that residents who live in retirement communities experience as they transition along the continuum of care. The purpose of this DC project with Westminster Village is to explore older adults' transitions across the continuum of

care through research, interviews, and the implementation of client-centered, evidence-informed interventions with a focus on well-being and QoL.

Needs Assessment

The needs assessment consisted of a community profile, site interviews, and a survey of staff to gather perception of site needs. The first phase, a community profile, described Tippecanoe County's social and demographic factors. The second phase included site interviews and a tour, which helped the DC student become familiar with the retirement community staff, the layout of the building, and services available at Westminster Village. In the third phase, the student developed a survey to identify a more specific focus for the project. Following the needs assessment process, the DC student conducted a literature review to further develop the project's purpose and desired outcomes.

Phase I: Community Profile

Westminster Village is a retirement facility in Tippecanoe County, Indiana that serves the Greater Lafayette Area, including some residents from surrounding rural areas such as Benton and White Counties. These counties are accessible by State Road 231 and State Road 52, which are heavily traveled roads that span through the Greater Lafayette Area. State Road 52 runs near Westminster and provides access to services throughout the community such as grocery stores, drug stores, medical providers, walking trails, and places of worship, all within a 10-minute drive. A Payless grocery store and a seasonal farmers market are also within walking distance. Westminster Village is located two miles from Purdue University, which allows for connections with Purdue University (Westminster Village, 2025). Westminster Village is located within ten minutes of Interstate 65, which provides direct routes to the larger cities of Indianapolis and Chicago. Traveling Interstate 65 locally provides easy access to services throughout the

community, including hospitals, restaurants, and stores. There is a city bus stop right outside of Westminster Village, which allows for transportation throughout the county. Westminster Village also owns a small bus, which takes residents on community outings.

According to the U.S. Census Bureau (2023), Tippecanoe County has a median household income of \$54,168, which is lower than the median income for Indiana as a whole. When considering Tippecanoe County as a whole, 12.6% of the population is older than 65, 13% speak a language other than English at home, 19.7% live in poverty, 6.7% have a bachelor's degree, 42.1% are from a married couple family household, 31.7% have never been married, 74.5% are white (non-Hispanic), and 10% report some form of disability (U.S. Census Bureau, 2023). This community profile provided a greater understanding of the Greater Lafayette community that Westminster residents call home.

Phase II: Site Visit and Interview

Phase II of the needs assessment included an interview with the DC coordinator and members of the Westminster Village team, including the life experience manager, administrator, and therapy director. During the interview, the DC student asked questions, inspired by an occupational profile, which considered supporting and inhibiting factors of the environment, performance patterns, and desired outcomes for the project (American Occupational Therapy Association, 2020). Questions addressed what a typical day looks like for staff and residents, challenges in service delivery, transitions between levels of care, and ideas for project sustainability. Sub-questions were developed to further clarify issues that emerged. This approach laid the foundation for maintaining an individualized perspective through the planning and implementation stages of the capstone experience (American Occupational Therapy Association, 2020).

This phase also illuminated the variety of services across Westminster Village's continuum of care. The community has a focus on wellness, offering art, fitness, music, spirituality, sensory, and educational programs. Additional services offered include therapy, nursing, personal training, transportation, and community caregiving (Witt et al., 2024). The community is set up to allow residents access to outdoor, sensory, activity, and fitness areas in an environment that does not feel institutional. Dining areas are open to all residents of Westminster Village, allowing for social interaction among people residing in different levels of care (Witt et al., 2024).

Through the interview process, the Westminster Village team and the DC student discussed ideas for the capstone project. One idea considered was a focus on becoming informed about evidence-based practices within the scope of OT, including fall prevention. Witt et al. (2024) discussed how the community provides fall-prevention training for staff and client-specific interventions after a resident falls or presents with decreased functional mobility. Another proposed focus was examining transitions along the continuum of care in the context of QoL and well-being.

Phase III: Continuum of Care Survey

After engaging in Phase II of visiting the site and conducting interviews with Westminster Village team members, the DC student identified fall prevention, clinical skills development, and services across the continuum of care as potential project focus areas. The Westminster Village team expressed interest in each of the areas and demonstrated flexibility in how the project would take shape. Following an examination of relevant literature, a survey was created to refine needs, gather information about the site's current state, and guide project planning. Qualtrics survey (2024) questions are displayed in Appendix A.

Nine staff members who work with individuals across the continuum of care completed the Qualtrics survey (2024). Of the respondents, 89% noted changes in routines, 67% identified safety awareness, and one respondent noted grief following loss around transition as barriers to transitioning between levels of care. Of the respondents, 78% found changes in routines, and 44% identified role loss or change, community engagement, and safety awareness as areas they would like to see addressed. Most respondents reported that their preferred method of service delivery was one-on-one sessions, and 67% indicated that residents in AL and memory care would benefit from addressing challenges associated with transitions along the continuum of care. The results of the survey contributed to an understanding of the site's needs and the development of project goals.

Literature Review

After completing the needs assessment, the DC student conducted a preliminary review of the literature to begin identifying what the community and site need was as related to OT practice. By 2030, one in six people in the world will be aged 60 years or over, increasing to approximately 1.4 billion (World Health Organization, 2022, para. 2). The growing population of older adults, driven by the Baby Boomer generation aging into older adulthood, highlights the need for additional research, financial resources, and services to provide reliable senior living residence options, promote QoL, and ensure the safety of older adults as they age.

The literature review aimed to explore older adults' lived experiences and identify OT intervention approaches across the continuum of care. The Occupational Therapy Practice Framework (OTPF) outlines the OT domain and process (American Occupational Therapy Association, 2020); this framework provides the structure of this literature review through incorporation of outcomes, contexts, and interventions. The DC student selected literature

through searching PubMed, Google Scholar, and American Journal of Occupational Therapy.

Primary search terms focused on QoL, well-being, and self-efficacy in older adults; intervention approaches; fall prevention; and transitions across the continuum of care.

Quality of Life and Well-Being in Older Adults

QoL and well-being are targeted outcomes for older adults' everyday lives, which are defined by experts in multiple ways. For example, according to Toledano-González et al. (2019), QoL can be defined as “the optimal state of well-being in the dimensions of health (i.e., physical, mental, social, emotional, and spiritual), while well-being is the result of an active process aimed at improving the individual's lifestyle” (p. 283). Furthermore, Mueller et al. (2023) define well-being as “the state when older adults have the physical, social, and psychological resources they need” (p. 1).

QoL and well-being are classified as outcomes within the scope of OT practice that guide OT services and intervention approaches. Outcomes in OT “are the end result of the occupational therapy process; they describe what clients can achieve through occupational therapy intervention” (American Occupational Therapy Association, 2020, p. 65). Incorporation of QoL and well-being outcomes in practice may look at improving participation in everyday life and enhancing one's sense of belonging (American Occupational Therapy Association, 2020). However, before being able to achieve outcomes such as QoL and well-being with clients, occupational therapists must first consider contexts, which “are influenced by the interplay among performance patterns, performance skills, and client factors” (American Occupational Therapy Association, 2020, p. 7). Context within the case of this DC supports approaching treatment from a holistic and client-centered perspective.

Context

Contexts include personal and environmental factors, which interact to facilitate or inhibit QoL, well-being, and self-efficacy for older adults across the continuum of care (American Occupational Therapy Association, 2020; Toledano-González et al., 2019). Personal factors include components of an individual's identity such as age, gender, culture, lifestyle, behavioral patterns, education, and health conditions (American Occupational Therapy Association, 2020). Environmental factors include the natural environments where an individual spends his or her time, support and relationships, technology, attitudes, and services (American Occupational Therapy Association, 2020).

Social support and social participation in one's environment have been linked to QoL outcomes (Duppen et al., 2019). While social participation throughout each stage of life may vary, social networks are associated with providing support through transitions (Duppen et al., 2019). For example, becoming a widow or losing friends to death or disease may cause the individual to feel more vulnerable, less confident, and feel loss of social support (Duppen et al., 2019; Weiss et al., 2022). Through these transitions, it is common for older adults to gravitate towards social support that has remained constant throughout life (Weiss et al., 2022).

The scenario regarding transitions and gravitation toward social support outlines what happens when an individual has social support present, which facilitates social participation (Weiss et al., 2022). Mohler and Miller (2020) address social participation in the context of AL facilities through barriers to social participation including a lack of meaningful activities, failure to adapt activities to meet the functional capacity of participants, and presence of health conditions impacting their ability to engage in activities. In the same study, participants identified that facilitators to social participation include incorporating activities that promote

cognitive well-being, physical well-being, and camaraderie (Mohler & Miller, 2020). Evidence suggests that individuals can improve physical and psychological health outcomes through participating in activities that provide a sense of purpose, such as engaging in the community, participating in social roles, and learning new skills (Owen et al., 2021).

An additional focus area for Mohler and Miller (2020) and Fritz and Hu (2022) is resilience, which can be viewed as a personal factor facilitating social participation when it is present or as a barrier to participation in terms of frailty when a decline in resilience occurs. Mohler and Miller (2020) describe resilience as “psychological and biological strengths required to master change successfully” (p. 265). In contrast, Fritz and Hu (2022), approach resilience from the perspective of frailty. As individuals age, some experience frailty, which is “a decline in resilience across one or more domains of functioning (e.g., physical, social, psychological) that reduces a person’s ability to respond or to recover from stressors” (Fritz & Hu, 2022, p. 1). Frailty, both physical and psychological, is not a normal part of aging. Rather, it is a common condition that many older adults experience, which impacts QoL (Fritz & Hu, 2022). Older adults experiencing frailty often present with personal factors such as balance problems, slower reaction times, and reduced community mobility (Duppen et al., 2019). Owen et al. (2021) further discuss how both frail and non-frail older adults commonly have functional limitations that prevent them from participating in occupations that bring them a sense of purpose.

Transitions to New Environments

Scheibl et al. (2019) discussed how one’s health conditions, independence levels, available support, and other personal factors may contribute to an older adult relocating to a new environment, such as long-term care (LTC) or AL. This may be stressful for the older adult and contribute to an increase in anxiety, confusion, and depression. Some individuals may experience

social isolation if they move to a distant residential care setting that is closer to their children, but the children do not have time to visit. Relocation may be met with feelings such as regret, loss, acceptance, resignation, and reduced loneliness (Scheibl et al., 2019). Williams-Roberts et al. (2020) found residing in a new environment with an unfamiliar set-up has been linked to an increased risk of falls. Mueller and Van Puymbroeck (2021) recommended adjustment strategies such as participation in health promoting activities, spiritual activities, finding new routines, placing familiar items in rooms, and becoming familiar with the facility and staff before moving in (Mueller & Van Puymbroeck, 2021).

Intervention Approaches

When working with older adults in retirement communities, there are a variety of intervention approaches and objectives for OT services. Group interventions compared to individual interventions present with strong evidence for facilitation of medication management and adherence (Feldhacker et al., 2022). Group and individual interventions addressing activities of daily living (ADL) training, sensorimotor stimulation, cognition, and psychosocial skills can be beneficial. Participants in group intervention reported higher psychosocial well-being across all domains and increased self-efficacy compared to individualized approaches, due to more opportunities for social relationships and feedback (Toledano-González et al., 2019).

Mitterfellner et al. (2024) discuss how individual and group-tailored leisure programs, comprising occupation-based and meaningful self-care and leisure activities, aided in significant occupational performance improvements. Moderate evidence exists for individualized interventions for ADL outcomes focusing on motor and sensory demands with the just-right challenge (Feldhacker et al., 2022). Greater independence in ADL tasks has been found through occupation-based goal setting and practice at the resident level (Mitterfellner et al., 2024).

Another individual intervention approach outlined by Fritz and Hu (2022) focuses on habit formation and reduction of frailty risk factors. Researchers focused on modifying occupations, activity patterns, and dietary habits through conversations about daily routines and how to modify the environment to promote habit formation. Key strategies include increasing self-efficacy through activities such as goal setting, barrier resolution, and application of habit formation strategies in daily life (Fritz & Hu, 2022).

The Promoting Meaningful Activities by Occupational Therapy in Elderly (ProMOTE) intervention is an evidence-based intervention for older adults designed by De Coninck et al. (2024) that is based on the Medical Research Council (MRC) framework. The MRC framework includes development, feasibility and piloting, evaluation, and implementation phases. ProMOTE focuses on health promotion and emphasizes shared decision making, implementation of meaningful activities, adaptation of the intervention plan as needed, and evaluation of effectiveness of the intervention (De Coninck et al., 2024). Common outcomes of the ProMOTE intervention include functional performance, QoL, and social participation. During goal creation, ProMOTE incorporates components of motivational interviewing (MI) (De Coninck et al., 2024). Lianov (2020) describes MI as an evidence-based practice commonly implemented when one is thinking about making a change, often with management of health behaviors and chronic diseases. MI focuses on overcoming ambivalence, improving self-efficacy, and promoting autonomy through collaboration and accurate empathy (Lianov, 2020).

Preventing Transitions to Higher Levels of Care

A focus on preventing transitions to higher levels of care can begin anywhere along the continuum of care, including when an older adult has just transitioned to a new level of care. Son et al. (2024) conducted an eight-year longitudinal study examining transitions from AL to

nursing homes. The researchers discovered that older adults who remain physically active, focus on ADL independence, and maintain better mental health have a lower risk of transferring to a nursing home compared to those who are not physically active (Son et al., 2024).

An additional approach to delay or prevent transitions to higher levels of care is fall prevention. According to Schafer et al. (2023), fear of falling impacts up to 92 percent of older adults. Williams-Roberts et al. (2020) discussed how a critical component of preventing falls is conducting fall risk screenings, which often include a history of falls, gait, and balance abnormalities. It is necessary to use a variety of approaches to determine fall risk, because it is not a one-size fit all approach. Williams-Roberts et al. (2020) recommended that staff conduct fall risk screening at admission and routinely thereafter with reassessment in LTC settings when one experiences significant changes in health or function. Screening for fall prevention often includes review of previous fall history, medications, vision, cognition, postural hypotension, and one's overall environment (Williams-Roberts et al., 2020).

Lucas Molitor et al. (2021) discussed how multiple fall prevention program structures exist including programs addressing a single risk factor or multiple risk factors. Interventions address factors such as functional exercise, conditioning, balance training, dual task training, and environment modification. Multiple risk factor interventions include both customized and structured interventions (Lucas Molitor et al., 2021). Structured interventions often involve group programming. Schafer et al. (2023) described a group evidence-based program called Bingocize that focuses on incorporation of strength, balance, flexibility, and fall prevention education. Bingocize has been linked to outcomes such as a decreased fear of falling, improvements in physical activity levels, and decreased social isolation (Schafer et al., 2023). Other structured group interventions highlighted by Lucas Molitor et al. (2021) include modified

Tai Chi and Matter of Balance, which have been linked to a reduction in falls. When working with clients, occupational therapists should incorporate functional exercises linked to occupation, interdisciplinary care, and structured fall prevention approaches (Lucas Molitor et al., 2021).

Outcomes and Measures

Through discussion of personal factors, environmental factors, and intervention approaches, a foundation is set for further analysis on how outcomes like QoL and well-being can be measured. To better understand factors that influence QoL and well-being, both Mueller et al. (2023) and Plys and Smith (2020) implemented specific measurement tools to examine QoL and well-being in AL communities. Plys and Smith (2020) implemented the Patient-Reported Outcomes Measurement Information System (PROMIS) Short-Form Global Health Scale v1.1 and Expectations Regarding Aging (ERA-12) surveys to measure physical health, socioemotional health, mental health, social satisfaction, and expectations for the aging process in AL residents. The Mueller Assessment of Transition (MAT) highlighted in Mueller et al. (2023) measured levels of support, freedom, comfortability in new routines, and engagement in hobbies. Findings in Mueller et al. (2023) revealed that older adults transitioning into AL often experience threats to their well-being, such as loss of independence. When considering well-being through the lens of the older adults' perceived ability to achieve, maintain, or decline in function and well-being, individuals with greater expectations were more likely to achieve positive outcomes including improved socioemotional health (Plys & Smith, 2020). Both Mueller et al. (2023) and Plys and Smith (2020) identify a gap in the literature to measure outcomes of QoL and well-being for residents with dementia and cognitive impairments.

This literature review explored the outcomes of QoL and well-being, contexts, intervention approaches, and prevention of further transitions along the continuum of care.

Common elements included transitions across the continuum of care and challenges older adults often experience as they age.

Gap Analysis

The results of the needs assessment and literature review revealed two primary gaps to address. First, rehabilitation services at the site lacked up-to-date application of evidence-based practice. Second, the site did not have a specific focus on examining or addressing transitions across the continuum of care. These transitions can be associated with challenges of decreased independence, role loss, and changes in routines. Staff identified how decreased independence can negatively impact mental health and overall well-being as residents transition along the continuum of care (Witt et al., 2024). Staff concern aligns with findings from Toledano-González et al. (2019) as they discussed how autonomy, closely linked to independence, impacts people's perception of QoL, including mental and physical well-being. To address these gaps, the DC student developed goals to support clinicians as they endeavor to design evidence-informed interventions and to examine residents' transitions across the continuum of care with a focus on QoL and well-being outcomes.

Guiding Model/Theory

The Model of Human Occupation (MOHO) is a conceptual framework developed by Gary Kielhofner in 1980 that frames this DC project through offering a way to analyze occupation with an open-system approach (Kielhofner & Burke, 1980). Kielhofner and Burke (1980) describe how “the open system interacts with the environment by way of a process of input, output, throughput, and feedback” (p. 573).

Input is the information that enters the system from the environment, including social factors, environmental factors, events, and activities (Kielhofner & Burke, 1980; American

Occupational Therapy Association, 2020). Within the context of this DC experience, the social environment includes social support available through connections between residents and staff; among older adults, the social environment can extend beyond in-person means as it includes staying in contact with others through phone or mail communications (Morgan et al., 2022). The physical environment includes resources and equipment throughout the community in dining rooms, resident rooms, and activity spaces. Accessible set-up of home and community spaces facilitate active participation in activities as it contributes to increased balance of the person, environment, and occupation (Jo & Kim, 2022).

Throughput includes subsystems of volition, habituation, and performance (Kielhofner & Burke, 1980). The volition subsystem directs the system's choices for action through goals and interests while encompassing personal causation that influences self-efficacy (Kielhofner & Burke, 1980; Morgan et al., 2022). At Westminster Village staff promote self-efficacy by connecting with residents to develop care plans aligned with their values and interests. The habituation subsystem includes individuals' maintenance of roles and habits (Kielhofner & Burke, 1980). As residents transition along the continuum of care, they experience changes in roles and habits, such as no longer participating activities like cleaning, self-care, driving, or caregiving for family members as frequently or independently. Jo and Kim (2022) discuss how habituation is linked to how people spend their time, which further impacts role and occupational performance. The performance subsystem includes skills to produce action (Kielhofner & Burke, 1980). In the case of residents at the DC site, the performance subsystem includes individuals with varying cognitive abilities impacting their processing speed, problem solving, environmental navigation, and attention to tasks. Motor skills vary among residents. Some use mobility devices, while others ambulate without a device (American Occupational Therapy

Association, 2020). As individuals age, they often experience changes in motor and process skills, which impact their occupational performance (American Occupational Therapy Association, 2020).

Occupational performance is an action in the open system, which is considered output. Within the context of this DC, one goal was to motivate residents to engage in meaningful activities and enhance their occupational performance through action (Kielhofner & Burke, 1980). The final aspect of the open system is feedback which allows for changes and adjustments in performance (Kielhofner & Burke, 1980). Feedback in this DC experience promoted change and adaptation; this allowed for continuation of the open system and facilitated occupational performance (Kielhofner & Burke, 1980; Morgan et al., 2022).

Overall, MOHO is an open system that describes complex interactions between people and their environment (Kielhofner & Burke, 1980). Throughout this capstone experience, implementation of MOHO concepts guided intervention plans while considering each subsystem and adapted-treatment approaches to promote occupational performance.

Capstone Plan and Process

Project Plan

During the planning phase for this DC project, the student developed project goals and objectives through collaboration with the content expert and Indiana University OT faculty. The goals for this project are as follows and were modified over the course of the project to adapt to the needs of the facility:

1. The DC student will gather information by searching literature about transitions and reviewing relevant methods of data collection already completed for residents.
 - Objective 1: Determine specific areas of care transitions to be addressed in

- questionnaire through direct observation, considering aspects of the MAT tool and researching additional components of relevant assessment tools found in literature.
- Objective 2: Develop a Qualtrics questionnaire using findings from initial observations, research, and practitioner recommendations to serve as a comprehensive assessment that measures resident experiences with transitioning along the continuum of care including current measurements of QoL and well-being.
 - Objective 2.1: Ensure construct validity of questionnaire by seeking practitioner feedback on initial draft of questionnaire.
 - Objective 3: Create a questionnaire distribution plan including a timeline and process for data collection.
2. The DC student will administer questionnaire through interviews with residents according to the established plan.
- Objective 1: Administer questionnaire and reflect information in Qualtrics to measure QoL and how participants transitioning across the continuum of care perceive personal factors and transition experiences.
 - Objective 2: Utilize resident input, results from initial data collection, and research to create individualized care plans for selected residents.
 - Objective 3: Deliver interventions within the scope of occupational therapy to residents following individualized plans of care.
 - Objective 3.1: Facilitate resident engagement in meaningful occupations.
 - Objective 3.2: Improve resident participation in meaningful daily routines.
 - Objective 4: Ensure sustainability of project and intervention methods through

providing staff training and access to the resources created for future use.

3. The DC student will analyze the results of resident interviews and perform additional research on related themes that are applicable to the resident population.
 - Objective 1: Interpret qualitative interview results through a reflexive thematic analysis.
 - Objective 2: Interpret quantitative data through statistical analysis using tools such as Qualtrics and the Adult Well-Being Assessment.
 - Objective 3: Research themes identified through the interpretation process and apply to transitions across the continuum of care.

Capstone Process

The capstone process was split between five phases over the course of 14 weeks to meet the goals and objectives outlined above. The process outline can be found in Table 1 below.

Table 1*Capstone Process Outline*

Phase	Tasks
Phase 1: Weeks 1-2	Orientation to site Observe disciplines including OT, PT, and nursing Attend meetings for daily operations Participate in activities to meet residents
Phase 2: Weeks 3-4	Participate in activities to meet residents Plan and brainstorm project with staff and faculty Research literature and resident information Create questionnaire and interview questions
Phase 3: Weeks 5-7	Gather questionnaire feedback from interdisciplinary team Finalize questionnaire and interview questions Administer interviews in AL Interpret interview findings Research interventions and evidence-based practice Conduct follow-up intervention sessions
Phase 4: Weeks 8-10	Conduct follow-up interventions with AL residents as needed Extend interviews to residents in HEALTH CENTER Interpret interview findings Research interventions and evidence-based practice Conduct follow-up intervention sessions
Phase 5: Weeks 11-14	Interpret interview findings Continue follow-up interventions with residents as needed Research interventions and literature Discuss and implement project sustainability

Capstone Project Implementation

Implementation began with the design and modification of the Quality of Life and Well-Being through Transition Questionnaire. Participants were identified via the interdisciplinary team; this allowed for selection of residents who were reliable historians and experienced a transition along the continuum of care. Following the identification of interview participants, the DC student conducted preliminary research, including chart reviews, while ensuring that no identifiable or personal information was recorded. The student conducted interviews and provided follow-up evidence-informed interventions to support development and application of

clinical skills. To maintain anonymity, the pronoun “they” was used to refer to all findings regarding individual resident experiences, regardless of the gender of the actual resident participant. No personal health information was collected, and all interview data were stored in a deidentified and secure manner.

Questionnaire and Interview Question Creation

The Quality of Life and Well-Being through Transition Questionnaire was developed with a combination of DC student-created open-ended questions and questions adapted from pre-existing tools. These tools included the MAT tool, the National Council on Aging (NCOA) Adult Well-Being Assessment (AWA), and the Independent Living Health & Well-Being Questionnaire, which is a site-specific questionnaire focused on well-being (LCS, n.d.; Mueller et al., 2023; National Council on Aging, 2020). The AWA is a tool created by the National Council on Aging, which measures well-being and QoL among older adults. Questions related to the AWA questionnaire were interpreted as *suffering*, *surviving*, or *thriving* in the following categories: QoL, physical health, mental health, financial well-being, social and emotional support, meaning and purpose in life, and social isolation and loneliness (National Council on Aging, 2020). Open-ended questions targeted resident-specific experiences with transitions along the continuum of care. Questions asked about various factors, such as what led to their transition, supports, barriers, and unmet needs. A copy of the Quality of Life and Well-Being through Transition Questionnaire used for the interviews can be found in Appendix B.

To establish construct validity of the questionnaire, the DC student sought and implemented feedback from therapy, nursing, and social work disciplines. To ensure question relevance to OT practice, each question was related to the scope of OT using the OTPF as a guide. Common links to OT included targeting specific occupations, personal factors,

environmental factors, performance patterns, and performance skills. The student input all responses into Qualtrics to increase ease of interpretation and analysis of results (Qualtrics, 2025). A question about sleep quality was added after completion of five interviews, as multiple residents reported sleep as an issue.

Interview Administration

After creating the Quality of Life and Well-Being through Transition Questionnaire and ensuring construct validity, the interview process began. Twenty-seven interviews were conducted; 15 in assisted living, nine in the health center, and three who transition from the health center to assisted living or independent living. Interviews took place in resident rooms. Participants agreed to take part in a 30-to-90-minute interview and were informed that no identifiable information would be collected. Interviews began with open-ended occupational profile style questions including what the respondent did for a living and their family structure. At the conclusion of each interview, the DC student inquired about the potential for follow-up interventions or patient education based on barriers to occupational participation and QoL within the scope of the project. Residents identified their preferences for follow-up. Responses were documented by hand, transcribed by the researcher, and stored on a password protected server, and analyzed through Qualtrics software.

Evidence-Based Practice and Intervention

Based on interview findings, the DC student researched barriers to occupational participation identified by residents and staff to develop evidence-informed intervention plans and resources for occupational therapists at the site. Consistent with resident identified barriers, the student focused on researching low vision, sleep, rheumatoid arthritis (RA), and leisure activities. A spreadsheet was created to track findings in literature, plan interventions, and link

relevant resources. Although most research and interventions were not directly linked to transitions along the continuum of care, the student developed case study materials presented during an in-service to apply research and intervention findings to transitions.

Vision

Residents revealed challenges with vision that limited their participation in daily activities. Designing interventions and developing resources for residents who expressed visual limitations was a collaborative process between the DC student, the wellness navigator, and the therapy director. In the literature, Kaldenberg and Smallfield (2020) and Eklund and Ivanoff (2006) discussed how interventions for individuals with low vision conditions, such as macular degeneration, include client education, problem-solving training, adaptive devices, environmental modifications such as lighting, and adaptive strategies. Some effective approaches include increasing contrast and incorporating sensory substitution by increasing tactile or audio stimulation in the environment or during daily activities (Kaldenberg & Smallfield, 2020). The student applied literature findings to create a vision task checklist, found in Appendix C, to aid in better understanding how vision impacts residents' daily activities. These findings were translated into practice through providing patient education on contrast enhancement and technology accessibility settings.

To further support staff and residents, the student contacted local libraries, optometrists, and organizations to discover community-based low vision resources. A comprehensive vision resource spreadsheet was developed to equip staff with knowledge of community resources, and intervention approaches that address resident concerns about vision in the future. To apply interventions and resources to transitions across the continuum of care, the student created a case

study where a person with low vision learns to navigate an unfamiliar environment as they transition into AL.

Sleep

During interviews, residents commonly identified sleep as a challenge, with several rating their sleep quality as *fair* based on a scale of *excellent* to *poor*. According to the National Institute on Aging (2025), good sleep quality can help protect QoL and physical health, while poor sleep quality can lead to increased fall risk. In response, the DC student implemented client-centered, evidence-informed interventions. These were supported by literature recommending strategies such as environmental modifications, progressive relaxation, sleep hygiene education habit formation (Fritz & Hu, 2022; Smallfield & Molitor, 2018).

As recommended by Smallfield and Molitor (2018), the DC student implemented sleep hygiene education and a sleep diary during follow-up sessions. Initial interventions introduced the National Sleep Foundation (NSF) Sleep Diary and a sleep hygiene sheet to educate the residents about modifying sleep habits and the environment to improve sleep quality (National Sleep Foundation, 2021). However, the sleep diary was overwhelming for residents as there was too much information to fill out. The DC student later implemented the Pittsburg Sleep Quality Index (PSQI), a standardized assessment that addresses factors like bedtime, sleep latency, sleep disturbances, and interference of lack of sleep on participation in daily activities (Mollayeva et al., 2015). Two residents completed the PSQI; results guided tailored interventions such as deep breathing, visualization techniques, and sleep hygiene education. One resident's self-reported sleep quality improvement did not align with their rating from the initial interview, highlighting the complexity of sleep perception. The resident reported continued daytime sleepiness leading to naps and difficulty falling asleep at night. Based on the DC student's scope of practice and

training, the student recommended that the resident reach out to their doctor with concerns about sleep. An opportunity for future projects and interventions addressing sleep is for DC students or practitioners to obtain a cognitive behavioral therapy for insomnia certification, equipping them to further address sleep needs.

Additional Intervention Approaches

In addition to addressing vision and sleep, the DC student supported residents with challenges related to RA, leisure activities, and daily routines. To address RA, patient education was provided on disease progression, energy conservation, and joint protection techniques. Exercises were presented through demonstration and teach-back methods and modified based on the resident's symptom presentation.

Another resident required modification for the leisure activity of crocheting to promote occupational participation and performance. Evidence suggests that textile arts can be a method for coping with stressful situations, organizing thoughts, and improving QoL and well-being (Riley et al., 2013). Recommendations for crocheting included using an ergonomic crochet hook, alternating between tasks, taking rest breaks, and incorporating stretching routines to minimize stress on hands (Pope, 2018). The resident reported improved participation in crocheting following these recommendations provided through patient education.

Routine modifications were addressed through a home evaluation. The student made recommendations for environmental modifications, such as placing frequently used items for pet-care and ADLs in accessible spots, to promote safety and independence. Across each type of intervention, the student sought to integrate client-centered strategies into daily routines to promote well-being and occupational performance.

Project Evaluation and Results

To fully understand the needs of the residents who experience transitions at Westminster, narratives were collected as part of the evaluation process. Project evaluation was an ongoing process that began at the conclusion of interview administration and continued through the writing of this report. After transcribing written interview results, including open ended questions, into Qualtrics, the data was cross-tabulated, creating sub-groups within the research population (Qualtrics, n.d.). Sub-groups were created to discover response trends among residents in AL, the health center, and those who were in the health center and planned to transition back to IL or AL, identified as *soon to transition*. Qualtrics software presented results for Likert-style questions in the form of horizontal bar charts and tables to allow for visualization of data collected (Qualtrics, 2025). During interviews, many residents rated themselves between answer choices (e.g., *fair to good*) rather than selecting a single choice. The results were consistently transcribed as the lower of the two descriptions, which decreased specificity when relaying survey results and discovering trends among settings.

AWA Results

Analysis of the AWA questions, paired with Qualtrics results and the NCOA scoring criteria, allowed the student to determine how many residents were *thriving*, *surviving*, or *suffering* for each question (National Council on Aging, 2020). This method of interpretation helped the DC student discover trends when comparing AWA results among settings. Appendix D displays AWA results for each setting, providing an overview of well-being and QoL outcomes as related to current processes of the retirement community.

Residents in AL and the health center were asked to rate their perceived physical and mental health as *suffering*, *surviving*, or *thriving*. Chi-square results for perceived physical health

are below in Figure 1 and mental health results are below in Figure 2. For physical health, Chi-square analysis revealed a statistically significant difference with a large effect size ($p < .05$, Cramér's $V > .35$) (Qualtrics, 2025). AL residents were more likely to report their physical health as *thriving*, and none reported *suffering*. Conversely, most health center residents rated their physical health as *suffering*, suggesting a clear correlation between level of care and perceived physical health.

Residents' perceived mental health results were also statistically significant, although not as strong as physical health results. There was a large effect size ($p < .05$ and Cramér's $V > 0.35$) (Qualtrics, 2025). While no AL residents reported their mental health as *suffering*, results suggest they were more likely to report themselves as *thriving* when compared to health center residents. These findings suggest that individual residents' physical and mental health perceptions are not always correlated. For example, some residents do not perceive their physical health as *thriving*, but they report their mental health as *thriving*, showing that they have a more positive perception of their mental health.

Figure 1

Physical Health Chi-Squared Analysis

Physical Health

	Thriving (n)	Surviving (n)	Suffering (n)	Total (n)
Assisted Living	7	8	0	15
Health Center	0	4	5	9
Soon to Transition	0	1	2	3
Total	7	13	7	27

Note. $\chi^2(4, N = 27) = 14.7, p = .00536, \text{Cramér's } V = .522$

Figure 2*Mental Health Chi-Squared Analysis***Mental Health**

	Thriving (n)	Surviving (n)	Suffering (n)	Total (n)
Assisted Living	10	5	0	15
Health Center	4	1	4	9
Soon to Transition	2	1	0	3
Total	16	7	4	27

Note. $\chi^2(4, N=27) = 9.64, p = .0469, \text{Cramér's } V = .423$

Although not statistically significant, a trend was identified among AL residents, suggesting they were more likely to report higher levels of life optimism and sense of meaning and purpose in life compared to residents in other settings. Additionally, three AL residents and one health center resident did not respond to the life optimism question stating they were unsure of whether they will be alive in two years.

Remaining Likert-Style Question Results

The remaining Likert-style questions address medication management, cognition, community mobility, coping, ADLs, and sleep quality. Results are displayed in Appendix E below. More health center residents reported personal care performance as *fair* to *poor* when compared to other settings. More residents in the health center rated their ability to cope with changes as *fair* than those in other settings. Participants' perceptions may have been influenced by their current level of residence, but the individual categories did not show any correlations that would result in the need for intervention.

Qualitative Data Interpretation

The student printed Qualtrics results for each setting to further analyze qualitative data through a reflexive thematic analysis, which is a process created by Braun and Clarke (2006) that

focuses on generating and refining themes. Through thematic analysis, the generated themes included personal and precipitating factors, adjusting to environmental and routine changes, and the emotional landscape. Table 2 displays advice given by residents during interviews about transitioning across the continuum of care for future residents. Common responses among residents' advice include making the choice independently, lifestyle factors, and adjustment strategies.

Table 2

Resident Advice for Others Transitioning

Common Responses	Exemplar Quotes
Making the choice	<p>“Don’t wait too long for independent living, so there are opportunities to meet people and make choices independently.”</p> <p>“You need to make the choice. People are happier when they make the choice instead of being forced to move by family.”</p>
Lifestyle	<p>“Just stay active as you can – go to as many active living things as you can.”</p> <p>“Take advantage of the opportunities and ask questions.”</p> <p>“Take advantage of everything going on.”</p>
Adjustment strategies	<p>“Settle in and make yourself happy – bring what makes you happy.”</p> <p>“Get acquainted – draw them out, get to know others. Stay interested in people.”</p> <p>“Just try to be open to the new changes in your life and try to be open to new things.”</p> <p>Be patient. It does get better. The confusion gets less. The stress gets less.”</p> <p>“Accept what you’ve got, accept where you begin, use it as much as you’re able. If you change, adjust. Have an open mind and enjoy what you have as much as possible.”</p>

Evaluation and Outcomes Beyond Interviews

Throughout the implementation stage of the project, the DC student applied both research and clinical skills to address project goals and objectives. The student successfully developed, implemented, and analyzed interviews paired with Qualtrics survey (2025) completion. These processes provided insight into residents' perceptions of transitions along the continuum of care and gathered data about QoL and well-being among residents. Based on these findings, the student developed client-centered and evidence-informed interventions for residents.

Key limitations included the absence of a method for measuring the effectiveness of interventions or to assess resident participation and engagement in meaningful occupations and routines. Outcomes noted through patient education sessions included residents' verbalization of understanding routine modifications and strategies for RA management, sleep, and leisure activities. Routines were specifically addressed during one home evaluation, where the DC student recommended placing commonly used items at accessible heights. During a future follow-up session, the resident reported increased ease in daily routines as necessary items were in more accessible places. Future projects within this setting would benefit from creating intervention goals and implementing methods to measure results.

The DC student presented project findings during an in-service to seven members of the site's interdisciplinary team to ensure the project's sustainability. Attendees completed a post-in-service survey to measure knowledge attainment about transitions across the continuum of care. Many shared ideas to better address transitions in future practice. Among participants, 57% reported they *strongly agree*, and 43% reported they *agree* that they were more knowledgeable about resident transitions.

Discussion and Impact

Each resident interviewed across the continuum of care presented with unique transition experiences. Themes emerged related to personal and precipitating factors, environmental and routine changes, and the emotional landscape associated with transitions. One limitation is that findings may not fully represent all residents' experiences. Due to the limited duration of the DC project, many residents were interviewed about past transitions between levels of care, while fewer participants were actively transitioning at the time of the project. These retrospective narratives may have clouded the views of those who were happy in their current residence.

Personal and Precipitating Factors Shaping Transition

Multiple personal factors emerged through interviews with individuals across the continuum of care. All residents interviewed were older adults presenting with conditions impacting independence in daily life. Decreased functional mobility and balance contributed to falls among residents; with 26 out of 27 respondents reporting a history of falling. The following statistics reflect trends identified from open-ended interview responses and may not fully represent all respondents, as some residents described multiple factors leading to transition, while others may not have reported all influencing factors.

Across all settings, 44% reported falls or fractures as precipitating events for transitions to higher levels of care. Within the AL category, 40% of respondents reported a skilled rehabilitation or hospital stay accompanied by decreased independence and need for additional support, prior to moving to AL. These discoveries are consistent with findings from Scheibl et al. (2019) who discussed health conditions and decreased independence as factors precipitating transition. Of AL respondents, 40% identified their spouse's health as a factor leading to their transition to AL. For some residents, this reduced caregiving responsibilities in their daily

routines, while for others, their spouse soon transitioned to the health center, due to declining health. Some of these residents reported staying in AL after the passing of their spouse due to their own increasing needs.

An additional factor to consider that shapes transition among residents in this retirement community is financial stability, as 78% of respondents rated their financial well-being as *thriving*. Many residents or their spouses retired from professions such as medicine, academia, farming, and engineering. These professions are often associated with higher socioeconomic status thus contributing to increased financial stability in retirement. Although these results represent this retirement community, the findings may not represent older adults in general. The NCOA reports that over 17 million older adults are economically insecure (National Council on Aging, 2024). Henriques et al. (2020) found that lower socioeconomic status can be correlated with decreased QoL among older adults.

Adjusting to Environmental and Routine Changes

When residents moved to a new level of care such as AL or the health center, changes both big and small impacted adjustment to the environment and routines. Moving to a new environment came with a new set-up of personal belongings and furniture. Williams-Roberts (2020) discuss how an unfamiliar environment can increase older adults' risk of falls; therefore, a focus on fall prevention for transitioning residents is recommended in the future. Despite challenges associated with moving, 20% of AL residents reported a local moving company was a major support with the transition process as the movers set up belongings to resemble their previous residences.

An additional environmental consideration is the physical environment, which includes products and technology that influence daily functioning (American Occupational Therapy

Association, 2020). In this current project, the physical environment impacted residents' daily routines as the absence of a washer for laundry or a stove for cooking were related to increased reliance on other resources for clean laundry and food. For residents without laundry appliances or those recruiting outside help with laundry, they developed routines of gathering laundry in one space to be available for pick-up through housekeeping or community caregivers. One resident reported that receiving help with laundry allowed for increased energy levels to participate in other meaningful activities. Due to not having a stove for meal preparation, AL and health center residents reported adapting to changes in mealtime routines as the times were more structured and required forming activities from the rest of the day around mealtimes. Of respondents, 20% discussed how developing mealtime routines promoted social participation as residents had the opportunity to meet new and existing friends.

Enam et al. (2020) discussed how an additional barrier in LTC is the interruption of sleep during the night to monitor vitals or administer medications. During interviews, residents in both AL and the health center discussed how these interruptions, although occurring routinely, disrupted sleep and often negatively impacted energy levels to participate in daily activities. Multiple residents discussed how these interruptions required time to get used to as part of their daily routines. To address sleep interruptions, a recommended strategy included communicating with staff about lighting preferences to decrease visual stimulation during nighttime care.

Despite the changes in routines associated with transitions, 80% of AL respondents reported that they *agree* to *strongly agree* that they were comfortable with their daily routines at the time of the interviews. All health center respondents reported that they *slightly agree* to *agree* that they were comfortable with their daily routines, although none of them reported that they *strongly agree*. Mueller et al. (2021) highlighted how encouraging older adults to create

meaningful routines can aid in a more successful transition into AL. Therefore, future practice in this setting would benefit from gathering data related routines as residents transition to a new level of care.

The DC student interviewed three residents who transitioned back to AL or IL from a health center stay, impacting independence during the DC experience. Follow-up sessions occurred with these three residents to gain insight into their transition experiences. All residents discussed the concept of adapting to a new normal after returning home. Two residents discussed the challenge of learning to delegate responsibilities as they were primary caregivers for their spouse before their health center stay. They also discussed learning to adapt to changes resulting from their diagnoses or health events; this presented as learning to slow down, taking additional safety precautions, and modifying the setup of their home environment to meet their needs and increase accessibility. A greater focus in the future should be on addressing the individualized needs of people as they transition to a new living space.

Navigating the Emotional Landscape

Transitions across the continuum of care are met by a variety of emotions. Residents in each setting discussed feeling sad, anxious, content, angry, and nervous around the time of their transition. Some AL residents reported having time to process their move, alternatively, some health center residents experienced shock as they were not prepared for the transition.

Additionally, 33% of health center residents identified feelings of resignation during their transition to the health center multiple residents stated feeling resigned to the fact that they were moving to the place they would live for the rest of their lives. Despite the different feelings residents associated with transition, residents identified that seeking social support helped them work through feelings of anger, fear, and loss of identity. Of all residents interviewed across

settings, 59% specifically identified support from family and others as tremendous help during the transition process. These findings are consistent with Duppen et al. (2019) who discussed social support as a facilitator during transition.

An additional trend multiple respondents identified was grief. Across interviews, residents identified feelings of grief during transitions stemming from downsizing, leaving home, leaving pets behind, giving up driving, decreased independence, and loss of a loved one. Ekerdt and Sergeant (2006) discussed grief in the context of household disbandment, which involves giving meaningful belongings away to others as well as deciding what to sell, what to keep, and what to throw away. Consistent with Ekerdt and Sergeant (2006), multiple respondents discussed grief in the context of moving was associated with selling their house, figuring out what to do with their belongings, obtaining a storage unit, and figuring out who to give possessions.

Grief in the context of relationships presented differently across interviews with residents as some residents discussed how their spouse had passed away within the last year while others reported having a longer time to cope with grief associated with losing their spouse. Damianakis and Marziali (2011) discussed how grief following the loss of a spouse can lead to decreased well-being and emotions such as sadness, helplessness, fear, anger, and decreased sense of identity. For some residents, grief was paired with their transitions across the continuum of care as multiple residents moved to a different level of care to be with their spouses when their spouses' needs progressed beyond their caregiving abilities; some of these residents experienced another transition as they moved back to a lower level of care after their spouse passed. Despite challenges associated with the grieving process, social support and spiritual practices enhance the grieving process, oftentimes allowing for creation of a renewed purpose (Damianakis & Marziali, 2011). One resident's advice for coping with the loss of a loved one was "Don't try to

do it all yourself – it'll just prolong it. Find close friends or family or a doctor.” This resident’s quote highlights how seeking social support after the loss of a loved one can support the grieving process.

Impact and Sustainability

This project has expanded upon research by Mueller et al. (2021) and Enam et al. (2020) that helped set a foundation of examining facilitators and barriers present during transitions to different settings along the continuum of care. The student’s goal is to make the Quality of Life and Well-Being through Transition Questionnaire and interview questions available to future DC students or other retirement communities to assist them in examining and facilitating transitions along the continuum of care. Dissemination efforts include student participation in a poster presentation at the Cel Hamant lecture and publication through Indiana University ScholarWorks.

This project impacts the site as it provided insight into QoL, well-being, facilitators, and barriers among residents along the continuum of care. It served as a starting point to determine what was going well and what could be further addressed in everyday operations at the site. The student discussed with the site the opportunity for an increased focus on fall prevention, sleep, low vision, and daily routines within the context of care transitions. Lastly, this project impacted the student as it provided opportunities for strengthening skills such as leadership, advocacy, empathy, active listening, and interprofessional collaboration. Stover (2016) discussed how advocacy involves empowering clients to seek resources to increase occupational participation. The student implemented leadership and advocacy throughout the DC through empowering residents to advocate for their needs and clearly communicate to staff when they would like to participate more in their daily routines.

To ensure sustainability of this DC project, the student developed and distributed materials including an overview of interview findings that were presented through an in-service training. The student-created materials will remain accessible to staff for future use. These materials were shared virtually, including the interview findings and case studies that link evidence informed interventions to transitions along the continuum of care. In-service materials are displayed in Appendix F. The student also shared a spreadsheet including current literature about evidence-based practice recommendations for topics like low vision for older adults, sleep, and rheumatoid arthritis. This included a brief overview of findings from the literature, links, and resources to encourage evidence-informed practice among practitioners at the DC site. A second spreadsheet for low vision community resources was made available to staff members including the wellness navigator, AL director, and the therapy team to aid in connecting residents with necessary resources as they identify low vision needs. The student shared all spreadsheets in an editable format to allow staff to add to them as new resources and evidence surface over time. The Quality of Life and Well-Being through Transition Questionnaire was shared with clinical staff members to equip a future DC student to continue to move this project and practice area forward. The hope is that future interviewers will be able to apply findings from this capstone project and further develop interventions associated with living transitions and focus on easing transitions across the continuum of care for residents.

Conclusion

Examining transitions along the continuum of care in retirement communities is under-researched, and this DC project sought to explore these transitions. Through interviews, research, and intervention planning, the student has facilitated a greater understanding of transitions experienced by many older adults. This project emphasizes the importance of social support and

adaptability through transitions. Although the results from this project are not to be generalizable to all retirement settings due to small sample size and socioeconomic status of residents in this community, tools such as the Quality of Life and Well-Being through Transition Questionnaire with a focus on older adults' transitions along the continuum of care, could provide future health care professionals in retirement communities a method to examine their community's transition process and determine how their facilities meet the needs of residents as they transition across the continuum of care.

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Appendix A

WV Continuum of Care Survey

1) What do you perceive as the biggest barriers for individuals transitioning between levels of care? (select all that apply)

- Quality of Life (life satisfaction, self-concept, health, and functioning)
- Changes in Routines (changes in established sequences of activities that provide structure for daily life, such as changes in independence for morning self-care routine, cooking, bedtime routine, etc.)
- Changes in and loss of roles such as worker, home maintainer, cook, spouse, caregiver, parent, grandparent, driver, etc.
- Engagement in Community (social outings, religious events, shopping, card club, etc.)
- Safety Awareness (changes in safety due to altered cognition/sensation, fall risk, etc.)
- Other _____

2) How often do you CURRENTLY work with residents to address the following changes commonly associated with aging?

	Rarely/Never	Occasionally	Frequently	Always
Quality of Life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Changes in Routines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Role Loss/Change	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Engagement in Community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safety Awareness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



3) Which areas would you like to see addressed more? (select all that apply)

- Quality of Life
- Changes in Routines
- Role Loss/Change
- Engagement in Community
- Safety Awareness
- Other _____

4) What do you think would be the most beneficial approaches for my capstone project to address barriers present across the continuum of care? (select up to 2)

- Staff training / resource guide
- Facilitating small group sessions to address common challenges among residents (addressing routines, roles, etc.)
- One-on-one sessions with residents to address individual challenges
- Other _____

5) Which parts of Westminster's Life Plan Community do you believe would benefit most from addressing challenges associated with transitioning between levels of care? (Select all that apply)

- Independent Living
- Licensed Residential (AL and Memory Care)
- Health center / Skilled Care

6) What is any other information you think would be useful for me to know when planning my project?

Appendix B

*Quality of Life and Well-Being through Transition Questionnaire**

For the first three questions please imagine a ladder with steps numbered from 0 at the bottom to 10 at the top. The top of the ladder represents your best possible life, and the bottom of the ladder represents the worst possible life.

1. Indicate where on the ladder you feel you personally stand **right now**.

Best	10	9	8	7	6	5	4	3	2	1	Worst
------	----	---	---	---	---	---	---	---	---	---	-------

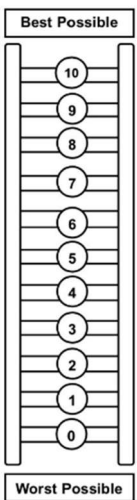
2. On which step do you think you will stand about **2 years from now**?

Best	10	9	8	7	6	5	4	3	2	1	Worst
------	----	---	---	---	---	---	---	---	---	---	-------

3. Imagine the top of the ladder represents the best possible financial situation for you, and the bottom represents the worst possible financial situation for you.

Please indicate where on the ladder you stand right now.

Best	10	9	8	7	6	5	4	3	2	1	Worst
------	----	---	---	---	---	---	---	---	---	---	-------



4. In general, how would you rate your physical health?

Excellent Very Good Good Fair Poor

5. How would you rate your sleep quality?

Excellent Very Good Good Fair Poor

6. In general, how would you rate your mental health, including your mood and your ability to think?

Excellent Very Good Good Fair Poor

7. How would you rate your ability to perform personal care (i.e., dressing, grooming, bathing, toileting)?

Excellent Very Good Good Fair Poor

8. How would you rate your ability to adjust to (or cope with) changes in your everyday life, including changes in your living situation?

Excellent Very Good Good Fair Poor

9. How would you rate your **physical ability** to get to the community dining room, mail room, and/or activities?

Excellent Very Good Good Fair Poor

10. How would you rate your **ability to find** the community dining room, mail room, and/or activities?

Excellent Very Good Good Fair Poor

11. How would you rate your ability to manage and/or obtain your medication?

Excellent Very Good Good Fair Poor

12. In general, how often do you get the social and emotional support you need?

Always Usually Sometimes Rarely Never

13. How often do you feel lonely or isolated from those around you?

Always Usually Sometimes Rarely Never

14. Do you think you are at risk for a fall?

Always Usually Sometimes Rarely Never

15. Do you have a history of falls?

Yes No

16. How strongly do you agree with this statement?:

“I feel comfortable with my daily routine.”

Strongly Agree Agree Slightly Agree Neither Agree nor Disagree Slightly Disagree Disagree Strongly Disagree

17. How strongly do you agree with this statement?:

“I lead a purposeful and meaningful life.”

Strongly Agree Agree Slightly Agree Neither Agree nor Disagree Slightly Disagree Disagree Strongly Disagree

Open-ended questions

1. What contributed to you needing to move to AL (AL) or current setting?
 - a. What was your biggest hesitation or biggest motivator?
 - b. Was there a driving event causing the move?
2. How did you feel when you moved (i.e., anxious, angry, nervous, sad, hopeful, trusting, content, etc.)?
3. Did you have any concerns when you initially moved? Have all of your concerns been addressed?
4. Were there any supports or resources that helped make your transition easier?
 - a. Were there any factors that made your transition harder?
5. Do you feel the set-up of your new home (or current living situation) meets your needs?
6. Do you feel as if you still have adequate independence?
 - a. Are there any factors limiting your independence (i.e., arthritis impacting FMC or other conditions impacting performance in ADLs)?
7. How did you adjust to developing new routines or navigating changes in roles?
8. Have your leisure interests and hobbies changed? Are any of your previous hobbies challenging for you to participate in that you would like to get back into?

9. What kind of activities have you participated in since moving to AL (or current setting)?

10. Do you have any advice for others who may be transitioning across the continuum of care (specifically AL as applicable)?

11. Please describe any other challenges you have experienced in your transition between levels of care.

12. Caregiver questions as applicable
 - a. Do you feel as if your needs are being met alongside taking care of your loved one?

 - b. Are you in need of any extra support?

*Likert-style questions for the Quality of Life and Well-Being through Transition Questionnaire were adapted from the Mueller Assessment of Transition, the National Council on Aging: Adult Well-Being Assessment, and the Independent Living Health & Well-Being Questionnaire through LCS.

Appendix C

Vision Task Checklist

Please check the boxes for each task that is challenging due to vision.

General

- Identification of items (with or without labels) such as personal care items or food items
- Naming colors
- Recognizing faces

Environmental Navigation

- Finding light switches
- Locating items
- Navigating environment (finding rooms)

ADLs

- Getting toothpaste on toothbrush
- Showering
- Toileting
- Shaving
- Putting on makeup
- Picking out clothes
- Buttoning shirt
- Orienting clothing in the correct direction (i.e., finding tag)
- Eating/drinking (locating items on plate)
- Pouring liquid into a cup

Communication/Leisure

- Writing a check
- Using phone
- Using computer
- Reading newspaper/book
- Reading labels
- Reading a clock/watch
- Craft participation (i.e., threading a needle)
- Identifying coins

Please check what impacts being able to see during activities:

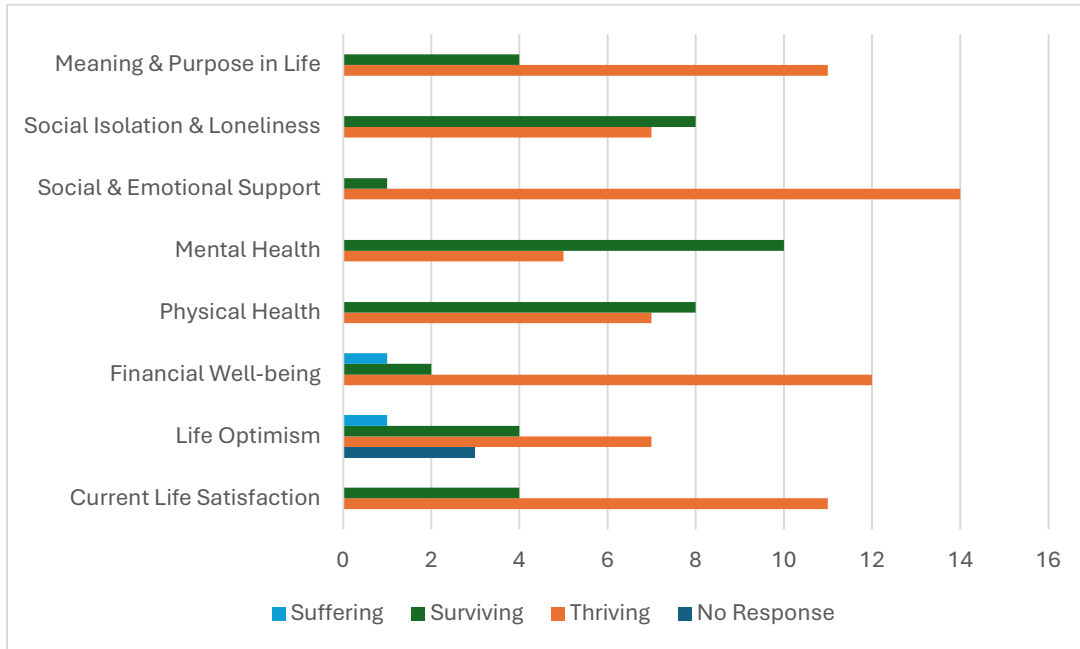
- Glare
- Blurriness
- Not enough light
- Decreased contrast
- Blind spots

Any other challenges:

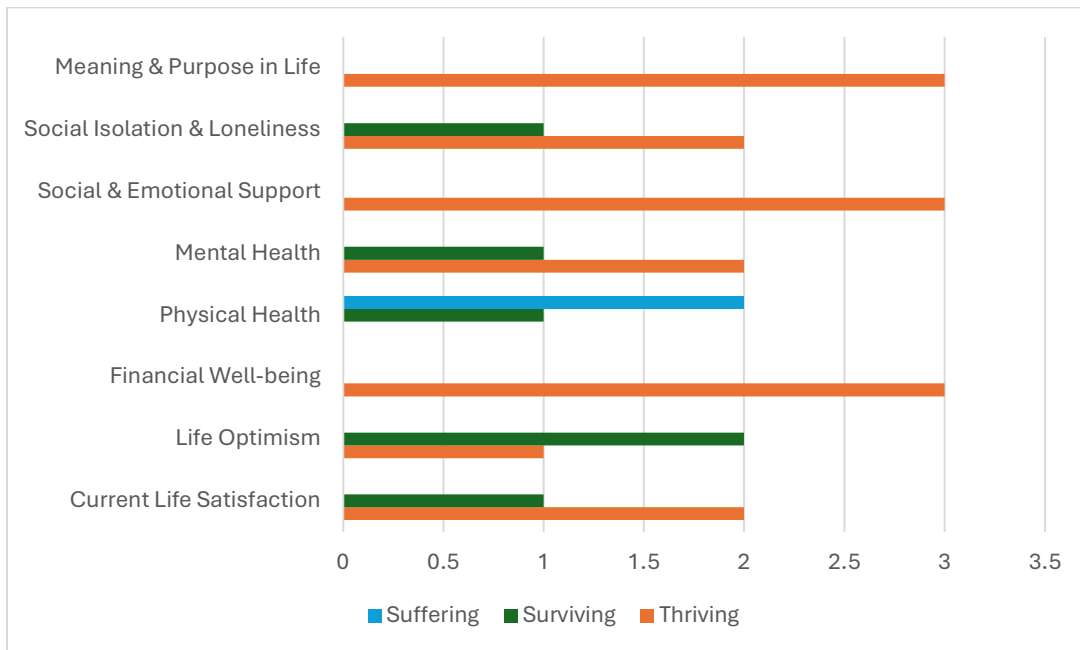
Vision Presentation:

Appendix D

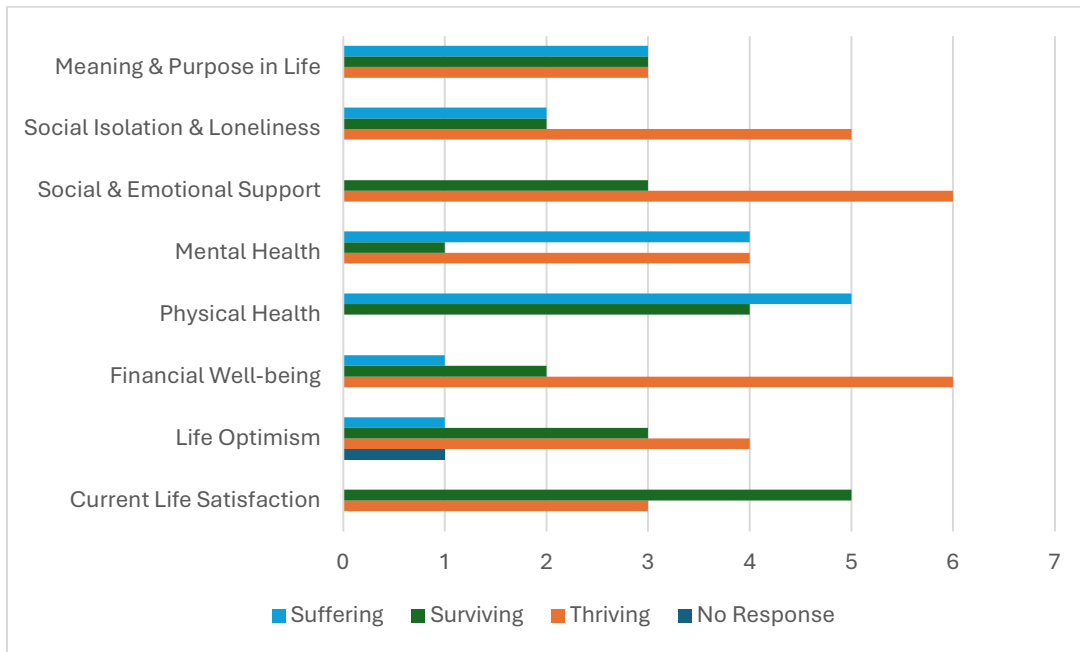
Assisted Living AWA Results



Soon to Transition AWA Results

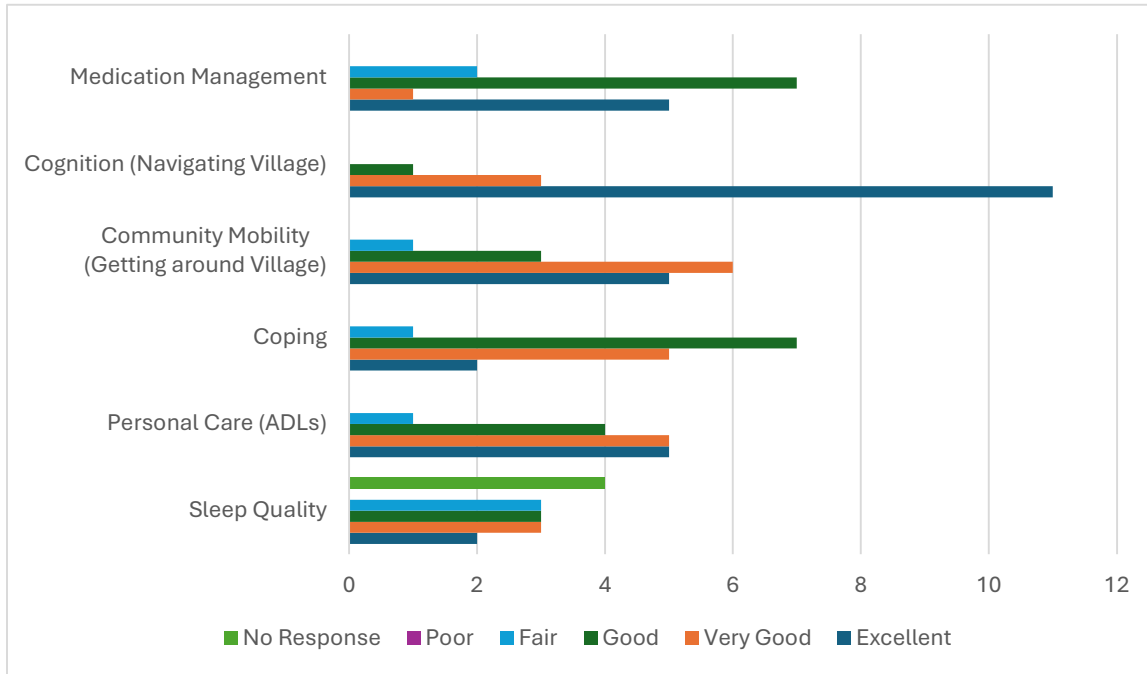


Health Center AWA Results



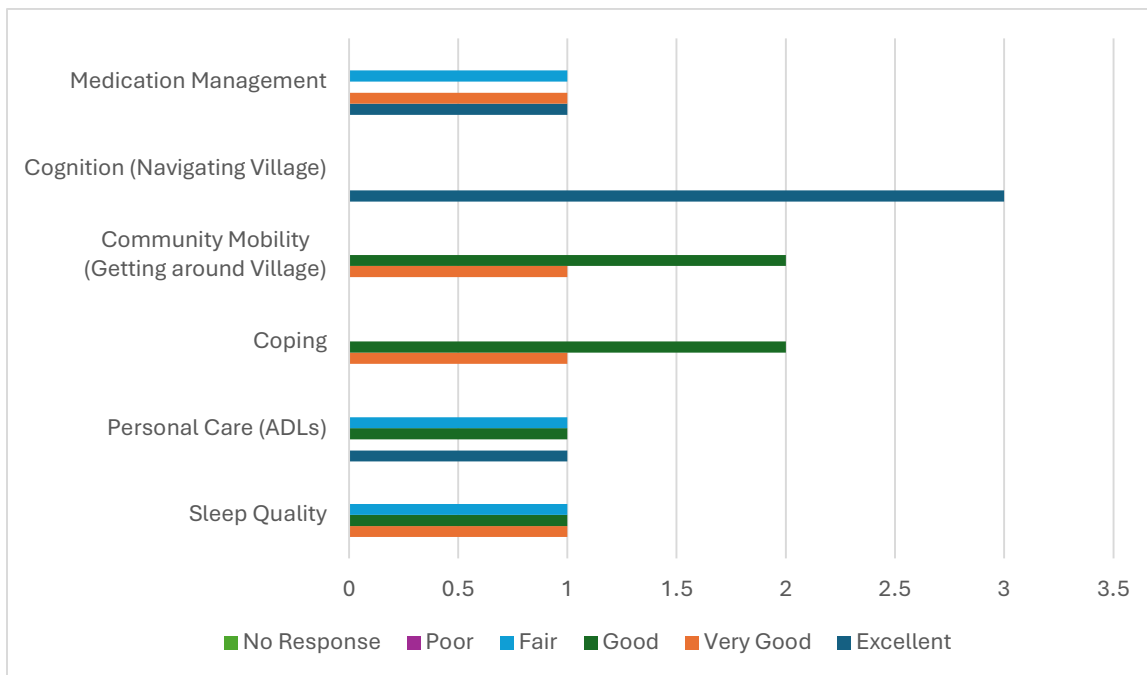
Appendix E

Assisted Living Likert-Style Questions

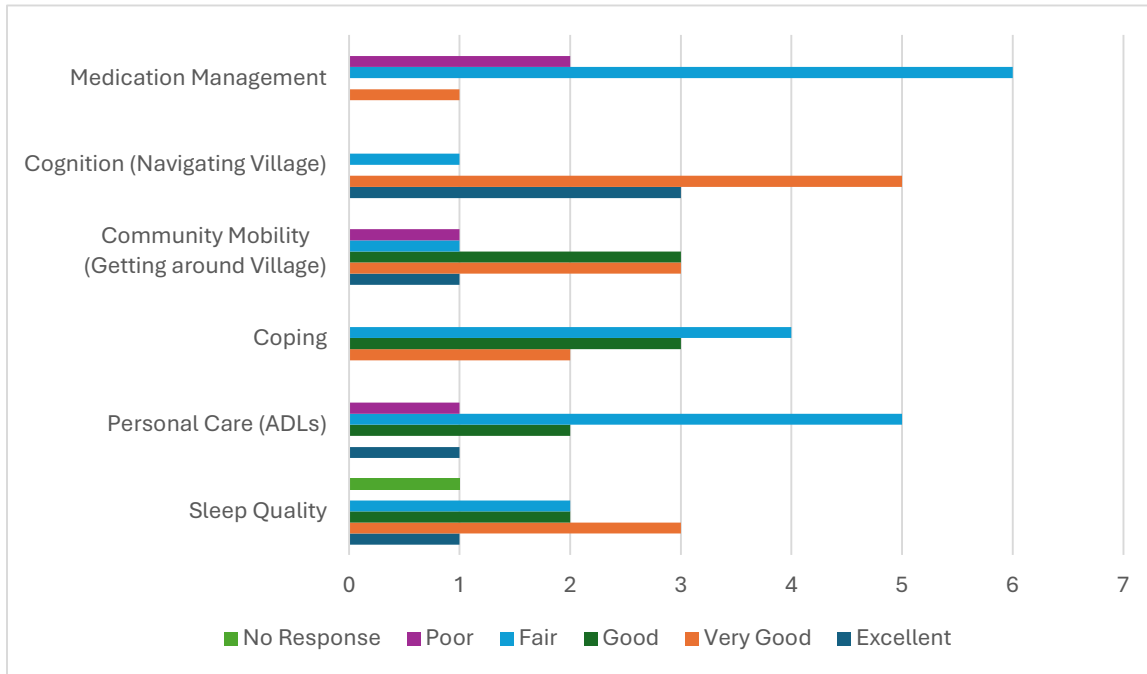


Note. Sleep quality question was added after first four AL interviews.

Soon-to-Transition Likert-Style Questions



Health Center Likert-Style Questions



Note. Sleep quality question was added after the first health center interview.

Appendix F

In-Service Materials

Examining Transitions along the Continuum of Care: Interview Findings

Assisted Living Results (15)

Domain	Suffering	Surviving	Thriving	No Response
Meaning & Purpose in Life	0	4	10	0
Social Isolation & Loneliness	0	8	7	0
Social & Emotional Support	0	10	14	0
Mental Health	0	10	4	0
Physical Health	0	8	7	0
Financial Well-being	1	2	12	0
Life Optimism	1	4	7	0
Current Life Satisfaction	0	4	10	0

- Greater proportion of residents rated life optimism and meaning and purpose in life as *thriving*.
- 80% of residents *agree* to *strongly agree* that they are comfortable with their daily routine; 13% stated they *neither agree nor disagree*.
- 40% of residents identified spouse's health as event leading to move to assisted living.

Health Center Results (9)

Domain	Suffering	Surviving	Thriving	No Response
Meaning & Purpose in Life	0	3	3	0
Social Isolation & Loneliness	0	2	5	0
Social & Emotional Support	0	3	6	0
Mental Health	1	4	4	0
Physical Health	0	4	5	0
Financial Well-being	1	2	6	0
Life Optimism	1	3	4	0
Current Life Satisfaction	0	5	0	0

- More residents in the health center rated their ability to cope with changes as *fair* than those in other settings, which may be linked to decreased resilience (Fritz & Hu, 2022).
- When comparing comfortability in daily routines among settings, no health center residents identified that they *strongly agree*.
- 33% of residents reported feelings of resignation when transitioning to health center.

Findings among Settings:

- Multiple residents did not respond to question about life optimism as they were unsure of if they will still be alive in 2 years
- 78% of all residents rated their financial well-being as *thriving*. Financial situation does not have as much of an impact of QoL than other settings where residents are lower income (Henriques et al., 2020).
- 96% of residents reported a history of falls.
- Common challenges and/or adjustments associated with transition:
 - Grief: loss of a spouse, downsizing, giving up driving, leaving pets behind
 - Changes in routines: interruptions, adjusting to mealtimes
- Current facilitators: social support (59%), resources available such as SOS, placing familiar items in rooms
- Additional challenges noted among residents: participation in leisure activities due to comorbidities such as arthritis and vision, decreased functional mobility, and sleep

Recent Transitions (3)

In the case of moving from the health center back to assisted living or independent living, residents adjust to the "new normal" which may look different for each person. This may look like:

- Learning to delegate more responsibilities (using Village Care for transportation and laundry)
- Adjusting to changes in roles and routines (with spouse, driving, resuming routines for planning and preparing meals, pet-care, taking out trash, etc.)
- Adapting to changes resulting from diagnosis/health event (learning to slow down, taking additional safety precautions, modifying set-up of environment)

Opportunities for further focus:

- More specific focus on transitions between levels of care
- Fall prevention: moving to an unfamiliar environment can lead to increased risk of falls (Williams-Roberts, 2020)

Resident Advice for the Transition

"Just stay active as you can – go to as many active living things as you can."

"Accept what you've got, accept where you begin, use it as much as you're able. If you change, adjust. Have an open mind and enjoy what you have as much as possible."

"I have no advice because that would cause people to expect too much. Oftentimes today people adjust to the best first, missing some of the joys in life created from experience."

"Get acquainted – draw them out, get to know others. Stay interested in people."



Sleep Case Study



Scenario

Upon chart review, an 83 year old male with a history of chronic fatigue is transitioning from a recent hospital stay due to a fall, presenting with general lower extremity weakness and shortness of breath. Prior to hospitalization, he resided in independent living with his dog; his daughter agreed to care for the dog and discouraged bringing the dog to assisted living. When returning from the hospital, he requires assistance for monitoring vitals and medication management. He uses a 4WW and requires CGA for shower transfers, set-up/supervision for shower using tub transfer bench, and increased time to complete all other ADLs stating his morning routine can take up to two hours.

Factors to consider:


- h/o PTSD, nightmares, left sided deafness, mild asthma
- Retired veteran, honorably discharged due to an incident leading to unilateral hearing loss; retired insurance adjuster
- Divorced; daughter lives 30 minutes away and is willing to support but doesn't go out of her way; estranged son
- Close circle of old friends and enjoys playing poker
- Lives within his means financially

Resident goals:




- 1) Increase active participation in village events
- 2) Improve sleep quality
- 3) Develop more consistent morning and nighttime routines

Questions to consider

- Are there any additional questions you would ask during the evaluation?
- What tools could you consider using to learn more about the resident's sleep?
- What kind of challenges would you anticipate when moving to a new environment?
- How would you address these challenges?
- How would this scenario be different if the resident was transitioning to the health center rather than assisted living?



Occupational Analysis : Breaking it Down

	Personal Factors	<ul style="list-style-type: none"> • Age: 83 years old • Gender identity: Male • Socioeconomic status: Lives within his means (although not financially stress free) 	<ul style="list-style-type: none"> • Psychological assets: Lonely, feels like a burden, depressed • Education: Some postsecondary after military • Social status: A few close friends, daughter, estranged son
	Environmental Factors	<ul style="list-style-type: none"> • Physical environment: Accessible environment with grab bars, long walk to dining room • Social support: Staff, daughter when requested, a few friends 	<ul style="list-style-type: none"> • Products and technology: 4WW, smart phone (difficulty using), tub transfer bench, TV • Systems and policies: retirement community policies
	Performance Patterns and Skills	<ul style="list-style-type: none"> • Performance Skills: Rushes through tasks, walks with occasional LOB, disengages when overwhelmed, difficulty regulating emotions 	<ul style="list-style-type: none"> • Routines: Watching TV in bed before bedtime, drinking morning and dinnertime coffee, Thursday night poker with friends, inconsistent sleep schedule • Roles: Father, friend, veteran <p style="text-align: right; font-size: small;">(American Occupational Therapy Association, 2020)</p>

Intervention Ideas

Pittsburg Sleep Quality Index (PSQI): self-report tool to measure sleep quality, sleep latency, sleep duration, sleep efficiency, sleep disturbances, sleep medication, and daytime dysfunction

National Sleep Foundation Sleep Diary: tool to track sleep quality and habits related to sleep; can be used as a basis to make modifications to factors impacting sleep

- May be appropriate depending on the person, although it may be overwhelming for some

Multi-component interventions: sleep hygiene education, relaxation techniques, modification of habits and routines (Schultz-Krohn & McHugh Pendleton, 2018).

- Mindfulness activities (although consider if PTSD may lead to desired or even adverse results)
- Sleep hygiene education: keep bed for sleep, limit caffeine before bed, avoid napping, etc. (see handout linked)

Additional sleep intervention approaches: Progressive relaxation, sleep schedule, problem-solving, exercise (Smallfield & Molitor, 2018)

Additional case specific considerations with intervention: Energy conservation techniques, considering how staff could remove barriers to sleep with timing and calm approach for medication/vitals

- Environment: being mindful of noise levels and intensity of lights turned on

Recommended Resources

PSQI:
<https://www.sleep.pitt.edu/sites/default/files/assets/Instrument%20Materials/PSQI-Instrument.pdf>

National Sleep Foundation Sleep Diary:
<https://www.thensf.org/wp-content/uploads/2021/02/NSF-Sleep-Diary-Rev-2-2021.pdf>

Sleep Hygiene Patient Education Sheet:
<https://www.therapistaid.com/worksheets/sleep-hygiene-handout>

Resource for Guided Imagery / Visualization:
<https://www.innerhealthstudio.com/relaxation-scripts.html#sleep-relaxation>

Possible Referrals: General practitioner for discussion of other referrals such as counseling, CBT for Insomnia (if indicated), medication, diagnosis of any underlying conditions



Vision Case Study



Scenario

Upon chart review, a 78 year old female with wet macular degeneration is transitioning into assisted living after a health center stay following a fall and has recently recovered from a hip fracture. She is now using a 4WW for ambulation, receives assistance with laundry, and is SBA for safety during showers requiring verbal cues for identifying personal care items.

Factors to consider:


- h/o Type I Diabetes, regular migraines, anxiety, depression
- Retired history professor with financial security
- No local family (children live 9+ hours away) and are busy with their families
- Her husband passed away two months ago
- Recently gave up driving
- She lived in independent living for six months before health center stay
- Difficulty recognizing faces
- Fading of colors (difficulty seeing thresholds in floor)

Resident goals:




- 1) Prepare simple snacks in the kitchen
- 2) Safely navigate apartment
- 3) Progress to needing distant supervision for showers and independent use of Medisets for medications

Questions to consider

- What are some anticipated challenges associated with the move?
- How would you address grief and anxiety?
- How would you address resident stated goals?
- What are additional safety considerations?
- What kind of resources would you recommend?
- Are there any necessary referrals to make?
- How would the present scenario be different if one had financial insecurity?



Occupational Analysis : Breaking it Down

 <p>Personal Factors</p>	<ul style="list-style-type: none"> • Age: 78 years old • Gender identity: Female • Socioeconomic status: Well off • Social status: recent widow with family far away, no mention of friends 	<ul style="list-style-type: none"> • Psychological assets: anxious about change, history of depression, grief (current), quiet • Education: Master's degree in history
 <p>Environmental Factors</p>	<ul style="list-style-type: none"> • Physical environment: Accessible apartment, minimal extra lighting, window with natural light • Social support: staff available, family (over the phone), pastor 	<ul style="list-style-type: none"> • Attitudes: grief over loss of husband • Products and technology: cell phone, 4WW, handmade throw rug, grab bars in restroom • Systems and policies: retirement community policies
 <p>Performance Patterns and Skills</p>	<ul style="list-style-type: none"> • Performance Skills: Expressing emotions, impact of vision on positioning during mobility and activities, transporting and locating items 	<ul style="list-style-type: none"> • Routines: cooking dinner in IL (more difficult with vision), driving to church on Sundays, morning self-care routine • Roles: Mother, grandmother, widow, parishioner of church, driver (previous)

(American Occupational Therapy Association, 2020)

Intervention Ideas*

Snack Preparation: enlarge labels on items, magnification, bump dots on microwave, dip measuring spoons rather than pouring, increase contrast with ingredients (using dark colored plates/cutting boards with light colored ingredients), liquid level indicator for hot beverages or for cold liquids, put index finger at the edge of the glass determine liquid level

Safe Navigation of the Environment: remove tripping hazards such as rug, keep rooms evenly lit, replace incandescent bulbs with compact fluorescent or LED bulbs, use lights at night

Shower: come up with system to identify items (i.e., placing one rubber band on shampoo and two on conditioner to allow for tactile recognition) or one light and one dark bottle to increase contrast, mark hot and cold temperatures on faucet to increase contrast

Medication Management: increase contrast between medication container/pills; open medications over a bowl to avoid dropping; large print schedule for medication management as needed

*Concepts throughout all activities: increase contrast, reduce patterns, improve lighting, reduce glare, set goals, and patient education/collaboration when creating materials

(Misericordia Health Centre, 2022; Kaldenberg & Smallfield, 2020)

Recommended Resources

Hadley (hadleyhelps.org): a great online resource with access to free workshops, podcasts, and discussion groups

Bosma Center for Visionary Solutions (bosma.org): In-home programs for seniors and working-age individuals who cannot travel to center; functional vision assessments, low vision aids, supportive counseling, in-home custom training

Easterseals Crossroads INDATA Services (eastersealstech.com) equipment lending library that allows to borrowing of assistive technology for free for 30 days; device demonstrations; monthly in person full day trainings about various topics; also has one page downloads for tech and vision

Possible Referrals: low visions specialist, trained professional in eccentric viewing (can help with face identification) - moderate evidence (Kaldenberg & Smallfield, 2020)

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