

THE PRESERVATION OF SPOUSAL AND PARTNER RELATIONSHIPS  
AMONG NURSING HOME RESIDENTS

by

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## ABSTRACT

The decision to seek placement in a nursing home can be difficult for both the residents and their families. This may be especially true for spouses or partners of the potential nursing home residents. Disruption of the attachment relationship following placement is likely influence the psychosocial well-being of nursing home residents. Although the responsibility of nursing home staff is to ensure psychosocial well-being, including awareness of the influence that separation can have on a spousal or partner relationship, little is known about services offered for the maintenance of spousal and partner relationships.

This mixed-method study explored the availability of services and activities that emphasize the preservation of spousal and partner relationships among nursing home residents. A survey instrument designed specifically for this study was administered with a sample of licensed social workers currently practicing in nursing homes in the states of Alabama, Georgia, Mississippi, and Tennessee. This study also explored the impact of the Coronavirus pandemic on relationships between nursing home residents and their spouses or partners. Survey results revealed that approximately 49% of respondents reported having a written policy to preserve these relationships; however, only 22% reported having a program to carry out the facility's written policy. Data from semi-structured interviews provided an opportunity for further exploration. Providing privacy, facilitating outings, and encouraging participation in facility activities were often discussed by these social workers. Additionally, participants shared barriers experienced in implementation, including privacy and cognitive capacity. Both survey

respondents and interview participants shared their perspectives on the impact of the COVID-19 pandemic and the resulting restrictions. Participants noted the negative effects of these restrictions on residents' spousal and partner relationships, as well as mitigating practices including the use of plexiglass or window visits, video calls, and encouraging residents to remain engaged with family members.

This results of this study have several implications for social work practice. Both current practices, as well as suggestions for additional services to preserve these important relationships, are highlighted. Nursing home social workers can utilize the results in the design and implementation of additional services to preserve relationships between residents and their spouses/partners.

## DEDICATION

This dissertation is dedicated to my husband, Webster Benjamin Shaw, my children, Harper-Pearl and Abigail Shaw, and my parents, Nathan and Treva Logan. I would not be where I am today without your love and support.

## LIST OF ABBREVIATIONS AND SYMBOLS

|              |  |
|--------------|--|
| <i>NASW</i>  | National Association of Social Work        |
| <i>ADL</i>   | Activities of Daily Living                 |
| <i>IADL</i>  | Instrumental Activities of Daily Living    |
| <i>HMO</i>   | Health Maintenance Organization            |
| <i>CSWE</i>  | Council on Social Work Education           |
| <i>MMSE</i>  | Mini-Mental Status Examination             |
| <i>BIMS</i>  | Brief Interview for Mental Status          |
| <i>CMS</i>   | Centers for Medicare and Medicaid Services |
| <i>GDS</i>   | Geriatric Depression Scale                 |
| <i>PASRR</i> | Pre-Admission Screening Resident Review    |

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## CHAPTER 1

### INTRODUCTION

#### **Context of Nursing Home Setting**

Every day nursing homes throughout the U.S. provide an array of essential services to over one million individuals (Harris-Kojetin et al., 2019). Although the primary purpose of these services is health-focused, nursing home facilities also have a responsibility to maintain the psychosocial well-being of each resident. The term psychosocial describes a range of factors that often play a significant role in an individual's physical, mental, and emotional well-being. These factors include social structures such as personal relationships, cultural norms, and general social activities and interactions, in addition to psychological structures such as mental health and emotional well-being (Loughry & Eyber, 2003; Upton, 2013). For older adults residing in nursing home settings, maintenance of psychosocial well-being is especially important as these individuals often experience adjustment to various health, physical, emotional, and social changes, including new health diagnoses, that can limit independence and also result in changes in management of daily activities and participation in social activities. Psychosocial well-being is also essential because of how it affects the overall quality of life of nursing home residents (Bowen & Zimmerman, 2008).

While the need to adjust to nursing home placement and maintain psychosocial well-being is essential for every nursing home resident, those who are part of spousal or partner relationships face additional challenges. In addition to adapting to a new care environment, these

residents may also experience a sense of loss due to a likely decrease in interactions with their spouse or partner.

Gerontological research about spousal relationships in the nursing home has primarily focused on staff attitudes about intimacy and sexuality among residents, with a significant amount of literature focusing on ethical aspects of intimacy for residents with dementia (Helen, 1995; Simpson et al., 2018; Walker & Ephross, 1999; Roelofs et al., 2015). Additionally, studies in this area also highlight the importance of intimacy for nursing home residents. For example, a quantitative study examining the psychosexual needs of nursing home residents found that participants expressed a need for physical closeness (45%) and a need for tenderness (75%) (Mroczek et al., 2013). In a similar study, Bullard-Poe and Powell (1994) interviewed 45 male nursing home residents and found that intimacy among this group was seen to contribute to quality of life.

Despite the significant role that intimacy plays in overall quality of life and psychosocial well-being among nursing home residents, no literature was found that described the types of services or facility practices or services that are available for the preservation of relationships between nursing home residents and their spouses or partners. Although nursing home regulations emphasize the importance of addressing each resident's psychosocial needs, little attention is given to policies and procedures to assist nursing home staff in supporting relationships among residents and their spouses or partners during a nursing home stay. This study explored service/program availability for residents who have a spouse or partner. The social work role in service delivery and development of specific policies and guidelines utilized for implementation of such services was also explored.

## **Social Work Context and Implications of the Study**

Along with many other setting-based standards, the National Association of Social Workers (NASW) outlined standards for social work practice in health care settings (National Association of Social Workers, 2016). These standards emphasize the knowledge and skillset that health social workers must possess to practice ethically and competently and outline the roles and responsibilities of social workers practicing in health settings. In addition to several other support-related responsibilities of social workers, the NASW also recognizes the duty of social workers to advocate for the needs and interests of clients and client support systems and to promote the delivery of services to vulnerable populations (National Association of Social Workers, 2016). More specifically the NASW also provides standards for social work services in long-term care facilities (National Association of Social Workers, 2003). The principles outlined in these standards emphasize the need for social workers to focus on several key areas in the long-term care setting, including the social and emotional impact of physical or mental illness or disability as well as the enhancement of physical and social functioning to preserve quality of life.

The NASW also emphasized the need for social workers to advocate for client interests and address social and emotional factors that may affect physical or mental health. These guidelines are in alignment with the NASW Code of Ethics, which emphasizes the importance of human relationships and places social workers at the forefront of psychosocial service provision in the nursing home setting (National Association of Social Workers, 2017). More specifically, nursing home social workers, more than other non-medical/professional supportive disciplines in this setting, have a duty to ensure minimal disruption of changes in relationships among residents

who have a spouse or partner, as these changes have the potential to negatively influence a resident's psychosocial well-being, physical health, and quality of life.

The results of this study have several implications for social work practice in the nursing home setting. First, this study not only highlights current relationship preserving practices in the nursing home setting but also identifies participants' views of ideal programs that social workers can use in their efforts to preserve these relationships. Additionally, this study brings to the forefront the need for the establishment of specific programs for nursing home residents who have a spouse or a partner. From a macro practice level, the results from this study may serve as a building block for the development of additional policies or changes to existing policies for the nursing home industry.

### **Research Questions**

The purpose of the study was to explore and identify what services, if any, are available to nursing home residents to preserve spousal or partner relationships. The specific research questions addressed were:

- 1) How do nursing home facilities preserve spousal/partner relationships of residents?
  - A. What interventions, programs, and activities are available to maintain spousal/partner relationships among residents?
  - B. What policies exist to guide availability and implementation of services that support spousal/partner relationships?
- 2) How do nursing home social workers and other staff facilitate the maintenance of relationships among residents and their spouses/partners?
  - A. What specific roles do social workers have in design and implementation of available services?

B. What roles do other nursing home staff have in design and implementation of available services?

### **Methodology**

This study used a mixed exploratory research method to identify policies, programs, and practices used by nursing home staff to preserve residents' spousal and partner relationships. Mixed method studies include a combination of “both quantitative and qualitative approaches to research for the purpose of a breadth and depth understanding and corroboration” (Creswell & Plano Clark, 2011, p. 4). This study utilized both quantitative and qualitative methods in the data collection and data analysis portion of the study. The sample for this included a total of 81 nursing home social workers practicing in the states of Alabama, Georgia, Mississippi, and Tennessee. Respondents completed a survey administered through Qualtrics online survey platform. The survey was created specifically for this study and was pre-tested with a total of four nursing home social workers; feedback was obtained prior to finalizing the instrument. The survey contained questions related to the respondent’s facility policies and services to preserve resident spousal and partner relationships; COVID-19 pandemic services and facility restrictions; facility routine practices and demographics; and respondents' professional and personal background information.

Additionally, the survey contained an invitation for respondents to participate in a semi-structured interview. The use of semi-structured interviews allowed for further exploration of common practices in the nursing home setting for preserving spousal and partner relationships, barriers experienced when carrying out these practices, and the impact of COVID-19 restrictions on these relationships.

## **The Researcher**

I prepared to conduct a dissertation using mixed method research techniques by taking quantitative, qualitative, and mixed-method courses. Additionally, my experience as a nursing home social worker coupled with a detailed review of current literature in the topic area aided me in the design of the study. I also consulted more experienced researchers for assistance with this study, as these researchers are aware of the best techniques to engage the sample population.

My interest in this topic began during my time in practice as a nursing home social worker. During this time, I had the opportunity to know a resident who was admitted to the facility on a long-term basis. Initially, and throughout the first couple of years of the resident's stay with us, the resident's spouse visited very frequently. The spouse not only participated in the resident's plan of care but also assisted the resident with meals and on occasion even played in-room games with the resident. As time progressed, the spouse visited the resident less frequently until visits trickled down to once or twice every other week. Although this decrease in visitation was due to several factors including the physical health of the spouse and additional family commitments, I began to think of ways that we as social workers might have intervened to preserve those frequent interactions that the couple once engaged in. I was motivated by this couple to gain a better understanding of what nursing homes in general do and can do to preserve relationships between residents and their spouses or partners. Because of these experiences I assumed that a resident's bond with their spouse or partner plays a significant role in the resident's emotional well-being. I also believed that an individual's emotional well-being has the potential to influence their physical well-being. In consideration of this assumption, I assumed that the disruption of or changes to this close bond may have a negative impact on the resident's mental and physical health. Therefore, the availability of services to maintain relationships

between nursing home residents and their spouse or partner are essential for nursing homes to provide as they work towards meeting the unique psychosocial needs of each resident.

## CHAPTER 2 LITERATURE REVIEW

### **Nursing Home Context**

Nursing homes vary greatly in organizational structure, the number of beds, and the characteristics of residents living in the facilities. Although available services may differ somewhat, most services are mandated by entities such as state health departments and the Centers for Medicare and Medicaid Services.

### **Characteristics of Nursing Home Residents**

The nursing home industry serves more than one million individuals receiving both short and long-term rehabilitative, skilled nursing services, and social, emotional, and psychological support services (Harris-Kojetin et al., 2016). While the medical and rehabilitative services are primary in this setting, residents also have access to housekeeping and homemaker services such as laundry, meal preparation, and personal care services (hairstylists).

Approximately 83% of nursing home residents are 65 or older, with 38% who are 85 or older. More than one-half (65%) are women, while men are less represented at 35%. The racial identities of nursing home residents are 75% non-Hispanic White and 14% non-Hispanic Black. Hispanic residents and those identifying with other racial groups represent 11% of all nursing home residents (Harris-Kojetin et al., 2019). No recent data were found regarding the marital status of nursing home residents. One study, encompassing the years of 1977 to 1999, revealed that approximately 7% of nursing home residents were married (Ness et al., 2004). In another survey conducted in 1996, researchers reported that approximately 16% of nursing home

residents were married (Agency for Healthcare Research and Quality, 2004). This data did not include couples who are unmarried.

### ***Nursing Home Placement***

Although eligibility criteria for nursing home placement depends heavily on facility location and resident payer source, the following four areas are often used to assess if an individual is appropriate for placement: Physical Functional Ability, Health Issues/Medical Needs, Cognitive Impairment, and Behavioral Problems (American Council on Aging, 2019).

**Physical Functioning.** Physical functioning refers to an individual's "ability to perform basic and instrumental activities of daily living" (Gerber et al., 2010). Basic activities of daily living (ADL's) are activities related to personal care, including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating. Instrumental activities of daily living (IADL's) refer to tasks associated with medication management, housework, and health maintenance (Centers for Medicare and Medicaid Services, 2008). Nearly all (96%) of nursing home residents need assistance with one or more ADL tasks. Assistance with bathing and dressing are most common, with 96% and 92% (respectively) nursing home residents requiring assistance. Assistance with eating is needed by fewer residents at approximately 60% (Harris-Kojetin et al., 2019). However, all residents in this setting receive assistance with IADL tasks.

**Health Problems and Medical Needs.** Nursing home services are often considered when individuals cannot address and meet their overall health or medical needs. Approximately 71% of nursing home residents had a diagnosis of hypertension. Additional medical diagnoses include Alzheimer's and other dementias (47%), diabetes (32%), arthritis (26%), and osteoporosis (12%). Diseases such as coronary artery disease, congestive heart failure, and stroke were

experienced by 38% of nursing home residents (Harris-Kojetin et al., 2019). In some cases, nursing home residents experience more than one medical diagnosis. For example, in a study exploring chronic co-morbid medical conditions in nursing home residents, a reported 27% of residents experienced both hypertension and dementia. Additionally, hypertension and arthritis were present in 20% of cases and 17% of residents had diagnoses of both arthritis and dementia (Moore et al., 2014). Each of the previously identified diagnoses may not only limit an individual's ability to care for themselves in their private homes, but they also require management of a complex medication regimen. The inability to care for personal needs or lack of caregiver support, coupled with poor medication management, often results in the consideration of nursing home placement.

**Cognitive Impairment.** Although Alzheimer's disease is the most commonly diagnosed dementia among nursing home residents, a range of the spectrum of dementia types may be present, including vascular dementia, dementia with Lewy bodies, and Parkinson's disease (Harris-Kojetin et al., 2019; Houlp et al., 2017). Because of the prevalence of dementia among nursing home residents, cognitive impairment is also evaluated in the placement process. Cognitive impairment often influences an individual's ability to make appropriate and/or safe decisions in daily living, thus individuals may be a danger to themselves or others without supervision and additional assistance.

**Behavioral Problems.** In some cases, behavior problems can be too difficult to manage to remain in their own home with a caregiver or in a non-skilled place of residency (e.g. assisted living) and therefore results in nursing home placement. The most common problematic behaviors observed in the nursing home setting include physical and verbal aggression, wandering, sexual inappropriateness, and hoarding (LaFerney, 2016).

### ***Types of Nursing Home Admissions***

The reason for a nursing home admission often falls into one of four categories: long-term nursing home care, short-term rehabilitation stay, Alzheimer's Care or Special Care units, and respite care (which is also on a short-term basis). All of these categories are considered 'skilled' care. The term 'skilled care' is defined as "nursing and therapy care that can only be safely and effectively performed by, or under the supervision of, professionals or technical personnel (Medicare.gov, n.d.). Services offered by nursing homes include 24/7 monitoring by medical staff, post-hospital and post-surgical care, assistance with ADL's, incontinence care, custodial care, medication administration, dietary services, and rehabilitation services (Marak, n.d.). Also, memory-care homes (or specialized units within facilities) offer specialized services such as wandering prevention and memory stimulating activities (Alzheimer's Association, 2021). Other non-medical professionals also offer supportive services in this setting, including social services, dental and podiatry services, business and financial services, and psychiatric services.

### ***Decision to Become a Nursing Home Resident***

The decision to utilize short- or long-term nursing home care is unique to each individual. Making this decision incorporates many complex factors. Individuals and their families often consider available insurance coverage and/or personal finances, level of care needed, social network support, potential resident and/or family wishes regarding agreement and/or disagreements concerning placement, and the location and reputation of the prospective facility.

Additional differences between long and short-term stays are also observed in payer source. Most short-term stays are funded primarily by Medicare and/or private funds, while

longer-term stay residents are primarily funded by Medicaid, private pay, or other nursing home insurance policies.

A complex set of medical and psychosocial factors contribute to the decision to seek placement on a long-term basis. Identified factors include incontinence, stroke, difficulties with ADL's, and instrumental activities daily living (IADL) such as cleaning, financial management, meal preparation, and grocery shopping (Andel et al., 2007; McCallum et al., 2005). Factors such as not having a caregiver or caregiver inability to meet the resident's care needs have also been identified (Blackburn et al., 2018).

Individuals who receive short-term skilled care services in a nursing home setting often do so for different reasons as compared to long-term stay residents. As previously mentioned, residents seeking short-term rehabilitation services can do so using Medicare Part A or a non-traditional Medicare source such as a Health Maintenance Organization (HMO) (Centers for Medicare and Medicaid Services, n.d.). Short-term skilled rehabilitative services and post-acute care are covered by Medicare and other private insurers following hospitalization for serious acute medical conditions or surgery such as total hip or knee replacements (Munin et al., 2010). The length of a 'covered' short-term stay will often depend upon the particular insurance and the medical/rehabilitative progress of the individuals receiving care. Typically, individuals utilize short-term services in a nursing home facility with an expectation of returning home or to their prior residence when treatment goals, such as re-establishing their prior level of physical functioning, have been reached.

The term 'respite' is defined as "planned or emergency care provided to a child or adult with a special need to provide temporary relief to the family caregiver of that child or adult" (Rose et al., 2015). This type of care provides caregivers with a 'break' from their caregiver

responsibilities. Although respite care for older adults is available in many settings including in-home, adult daycare centers, and respite camps, services provided in residential programs such as hospitals, nursing homes, and specialized facilities provide 24-hour health care services. In the nursing home setting, a respite stay may be as little as one day, with coverage of up to five days for individuals who receive hospice services covered by Medicare, Medicaid, or private insurances (Medicare.gov, n.d.; National Institute on Aging, 2017). However, individuals who do not receive hospice services and are seeking a respite may pay privately for these services if their private insurance does not offer assistance (National Institute on Aging, 2017).

### **Separation, Loss, and Adjustment**

Adjustment to nursing home placement may be difficult for the new residents as well as their families and friends. Individuals relocating to nursing home facilities may experience a range of emotions including anger, confusion, grief, and depression, while they navigate the new environment. Common among new admissions is a feeling of 'homelessness,' making it difficult to create a home-like environment (Family Care America, n.d.; Heliker & Scholler-Jaquis, 2006). While a sense of relief is often experienced by caregivers when placement occurs, this may be also accompanied by feelings of loss, sadness, and guilt associated with placement (Bramble et al., 2009). Both a physical and an emotional separation occurs for both the resident and their family members.

For older adults who are in romantic relationships with a spouse or partner, the decision to seek nursing home placement for partners has an added level of complexity. The couple may have concerns associated with the reality that their relationship will change as a result of their separation. This type of change has the potential to magnify the stress of a placement and the resulting emotional response. As a result, the health of both partners may be negatively affected.

Many studies have explored the effects of placement on an intimate relationship. For example, Førsund et al. (2014) explored experiences of losing ‘couple-hood’ when one spouse has been diagnosed with dementia and resides in a nursing home facility. Participants in this study reported feelings of loss and a sense of being alone associated with placement of a spouse in a nursing home. A similar study (Stadnyk, 2006) explored community-dwelling spousal adjustment to nursing home placement and activities that sustained identities amid transition into placement. Findings highlighted the importance of sustaining marital ties and identifying activities to assist with adjustment to the transition.

In a 1999 study, Sidell examined the experiences of 60 community-dwelling older adults whose spouses lived in a nursing home. Through interviews, participants in this study reported that they highly valued their marital relationship despite the difficulties encountered due to their current separation (Sidell, 1999). These participants were found to employ positive coping mechanisms, such as reframing and passive appraisal, that contributed to marital satisfaction (Sidell, 1999). Gladstone (1995) also identified the importance of maintaining active participation in the marriage; recognition of the role of independence and dependence; and understanding that spousal support coupled with facility services are all important in marital satisfaction.

Although the previously mentioned studies differ in methodology and study location, commonality can be seen in their identification of the role that the facility personnel have in the educating and training of staff, and in facilitating marriage-sustaining activities and/or ensuring privacy for residents who may have a significant other. This information is especially relevant for social workers in this setting as they promote the maintenance and importance of these relationships while also promoting the autonomy and self-determination of each resident.

## **Roles and Responsibilities of Nursing Home Social Workers**

According to CMS guidelines, nursing home facilities must “provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each individual resident” (Centers for Medicare and Medicaid Services, 2014). The inclusion of the term “psychosocial” suggests that nursing home facilities have a responsibility to implement a holistic approach when devising each plan of care. Nursing home social workers are often charged with ensuring that this comprehensive approach to care takes place.

Approximately 2% of all nursing home staff are social workers (Harris-Kojetin et al., 2016; Bureau of Labor Statistics, 2018). According to CMS, Medicare-certified nursing homes with more than 120 residential beds must have at least one social worker who holds at least a bachelor's degree in social work from a CSWE accredited program. Facilities with fewer than 120 beds are still required to provide social work services but are not mandated by CMS to employ a full-time social worker (Centers for Medicare and Medicaid Services, 2018). In many cases, primarily in large facilities, the social service department is led by a social service director. Approximately 62% of social workers in this head position possess a BSW, while only 35% possess an MSW. The remaining 3% of nursing home social service directors do not possess a social work degree (Social Work Policy Institute, 2010).

In the nursing home setting, through an interdisciplinary team approach, social workers collaborate with the other facility disciplines (nursing, rehabilitation, nutrition, etc.) to develop and implement an individualized plan of care for each resident. The social worker's primary contribution to the interdisciplinary team is ensuring that each resident's psychosocial needs are addressed. To achieve this goal, social workers are responsible for various activities including completing a mental health assessment, conducting psychosocial interventions, counseling

residents and their families, making referrals to other service providers, evaluating the resident's progress and functioning, preparing a discharge plan, and assisting the resident with palliative care (Rehnquist, 2003). Additional duties may include implementing behavior management programs, group work, and attending quarterly care plan meetings (Bern-Klug & Kramer, 2013).

Each of the social work functions have a vital role in shaping the nursing home experience for residents and serve the purpose of improving the quality of life and psychosocial well-being of each resident. In addition, nursing home social workers must also take into account spiritual and environmental issues that affect client well-being (National Association of Social Workers, 2016). Social workers are responsible to champion the psychological and social well-being of each individual resident.

Social workers use various tools to initially and continually assess and monitor each resident's mental health status, mood, social, cognitive, and environmental needs. Changes in mood, behavior, and cognition are assessed on an ongoing basis through observation and continuous interaction with residents. Also, in preparation for quarterly care plan reviews by the interdisciplinary team, more formal assessment measures may be used, such as the Folstein Mini-Mental State Examination (MMSE) or the Brief Interview for Mental Status (BIMS) for cognition, and the Geriatric Depression (GDS) to assess depressive symptoms (Castro et al., 2016; Chodosh et al., 2008; Li et al., 2015). Social workers also use behavior screening tools to assess baseline behaviors. Families' well-being is also assessed to understand the family members' adjustment to the residents' placement and the level of participation and interest that family members' have in supporting the resident's placement in the nursing home.

While assessments in this setting are an important part of social workers' tasks and responsibilities, in most cases these assessments serve to guide the intervention process as well.

Social work services provided in nursing homes also vary depending on each resident's overall goal for seeking nursing home services and an assessment of strengths, needs, and goals of care. For residents admitted to a nursing home facility to receive short-term rehabilitative services, social work efforts may focus heavily on discharge planning interventions, including referral to community services, because these residents will likely return to their previous living arrangement, such as a private home or assisted living facility. For longer-term residents, discharge planning services would likely not be the focus of social work service provision. Longer-term residents most often receive social work services that are primarily focused on care plan development as part of the facility's interdisciplinary health team and on achievement of a therapeutic environment adapted to each individual. For this group of residents, social workers have a vital role in ensuring that the evolving psychosocial needs of residents are met throughout their stay in the facility (National Association of Social Workers, 2003). After all initial admissions, residents' adjustment to the facility is a primary focus. During the first days and months residents often experience grief and a sense of loss due to the many life changes, both medical and psychosocial. Interventions utilized throughout the residents' stay may include individual and family counseling with residents and family caregivers (Social Work Policy Institute, 2010). Group work interventions may be utilized for adjustment of new residents or bereavement issues. Social workers also utilize reality orientation treatment with residents who may be experiencing confusion. In addition, in some states, clinically-licensed social workers, may also diagnose for mental illness (Rehnquist, 2003).

In some cases, social workers may also be responsible for completing Level One Screenings for residents. The Preadmission Screening Resident Review (PASRR) is a required legal document that must be completed before the admission of a resident into a certified

Medicare and Medicaid facility. This document is used to determine whether or not an individual with a mental illness is appropriate for placement in a nursing home facility. Social workers may also be called upon to re-submit a Level One screening for a resident if he or she receives a new mental health diagnosis while residing in the facility (The Alabama Department of Public Health, n.d.). Practitioners use all of the previously mentioned assessment tools and techniques to ensure that proper and individualized services are provided to encourage and maintain the psychosocial well-being of each resident.

While social workers in this setting carry out various tasks and interventions to address each resident's psychosocial needs, little is known about the availability of services specifically targeted toward maintaining marital/partner relationships among this group. The NASW (2003), in the *NASW Standards for Social Work Services in Long-Term Care Facilities* guide, and the Centers for Medicare and Medicaid Services (2017) both outline the importance of respecting each resident's right to privacy and ensuring psychosocial well-being. However, neither guide explicitly outlines the responsibility of social workers or facilities to recognize the influence of spousal or partner separation through specialized service provision. Since there are no specific mandates or guidelines regarding maintaining residents' spousal or partner relationships, the responsibility is on each individual facility to develop service provision in this area. This study explored the interventions and services available within the nursing home facilities and utilized by social workers to assist in the maintenance of marital and partner relationships.

### **Theoretical Perspective**

The impact of nursing home separation can be explored through attachment theory. In attachment theory, Bowlby describes the interaction and connection between a mother and her child and describes the importance that this bond has on the child's development (Bowlby,

1987). The theory suggests that “children come into the world with an innate drive to form attachments with their caregivers” (Bretherton, 1992). At the center of this theory is the presence of an attachment system. When this system is threatened by separation from the child’s caregiver, attachment behaviors are activated. In infants, these behaviors include feelings of anxiousness followed by crying. Attachment behaviors such as these remain activated until the attachment threat is eliminated and proximity of the caregiver is re-established (Hazan & Shaver, 1994).

Despite its development associated with maternal relationships, Bowlby suggested that the key concepts of attachment theory could be applied from the "cradle to the grave" (Bowlby, 1987). Hazan and Shaver (1994) further explored this concept and identified similarities between the “infant-caregiver” and “romantic partner” relationships. In each of these attachment situations, both (infant and romantic partner) feel safe when the other (caregiver and romantic partner) is nearby, engage in close intimate bodily contact, and feel insecure when the other is inaccessible (Fraley, 2010). Spouses often seek “closeness to their partners, experience distress if they become unavailable, derive a sense of security from their relationships, and turn to partners for comfort in times of stress” (Feeney & Hohaus, 2001).

Close relationships play a vital role in human physical, emotional, and mental development at all stages of life. The establishment and maintenance of close relationships is thought to be essential for personal well-being for most people (Freedman, 1978). For older adults, these relationships are especially important. The disruption of or loss of a relationship can affect older adults in many aspects of life including mental, social, behavioral, and biological (Das, 2013). Older adults who have experienced separation and/or loss are more likely to experience depression, unhappiness, and less close ties (Hunt, 2015). This group is also more

likely to experience health problems and practice unhealthy behaviors, such as poor eating and sleeping habits, and smoking, than their non-separated counterparts (Das, 2013). Use and potential abuse of alcohol and other substances also often becomes a risk among this group. (Hazan & Shaver, 1994)

As previously mentioned, various social, psychological, and biological factors can influence the mental health of any person. For older adults, these factors may include loss of independence, loss of or changes in social connections and contacts, and development of chronic or acute medical conditions (World Health Organization, 2016). The presence of mental health disorders can influence individuals' physical well-being and vice versa. A positive correlation has been demonstrated between chronic illness and mental health disorders, such as depression, in older adults (World Health Organization, 2016; National Institute on Mental Health, n.d.). This further emphasizes the importance of reducing stress and addressing psychosocial factors that may negatively impact the mental and physical health of older adults in the nursing home setting.

### **Mind-Body Connection**

Attachment theory demonstrates how outside stressors can influence an individual's physical state. The mind-body connection can be used to explore the relationship between a person's environmental stressors and their mental and physical health. Psychoneuroimmunology (PNI) is an interdisciplinary science that explores the relationship between the mind and the body. This science incorporates psychology, immunology, endocrinology, neuroscience, and psychiatry.(Leonard, 2008). Research in this area has recognized the means through which stressful emotions can alter an individual's physical health (Littrell, 2008). Panic attacks are one example of how stress and anxiety can affect physiological conditions. When stressful or

unfavorable situations occur, and anxiety is experienced, several systems of the body go into restoration mode to attempt to re-establish homeostasis. These systems include physical systems (nervous, cardiovascular, sweat glands, and respiratory effects), behavioral systems (foot tapping, pacing, or snapping), and mental systems (difficulty concentrating and problems with memory) (Rapee et al., n.d.). This example demonstrates how environmental influences, such as stress, and physiological responses are interconnected. Environmental and social stressors can influence physical aspects of the body. A threat to a social or romantic attachment (separation/stressor) may cause changes in mental health (such as symptoms of anxiety). This has the potential to affect physiological well-being. In consideration of attachment theory coupled with the concept of the mind-body connection, the influence of separation from a spouse or partner has the potential to negatively affect an individual's physical and mental health.

### **Research Questions**

The purpose of this study was to explore and identify what services, if any, are available to nursing home residents to preserve spousal or partner relationships. Little previous research has addressed this aspect of these older couples' well-being. An exploratory design guided the development of a quantitative survey and a semi-structured interview guide which were administered to nursing home social workers. The following research questions will be addressed.

- 1) How do nursing home facilities preserve spousal/partner relationships of residents?
  - A. What interventions, programs, and activities are available to maintain spousal/partner relationships among residents?
  - B. What policies exist to guide the availability and implementation of services that support spousal/partner relationships?

2) How do nursing home social workers and other staff facilitate the maintenance of relationships among residents and their spouses/partners?

A. What specific roles do social workers have in design and implementation of available services?

What roles do other nursing home staff have in design and implementation of available services?

## CHAPTER 3

### METHODOLOGY

The current study was exploratory in nature, as no previous research has examined services or programs available for residents and their spouses or partners. The goal was to gain a better understanding of the topic of interest (Neuman, 2020; Rubin & Babbie, 2017). This study utilized a mixed-method design. A quantitative survey explored the phenomenon of interest. Because of varying facility characteristics (number of beds, region, and number of staff), a quantitative method was efficient in collecting data from a large number of respondents. Additionally, after the survey was completed, qualitative data was collected from among the survey participants who expressed a willingness to be interviewed. This provided a deeper understanding of the phenomenon and resulted in a more accurate description of current practice trends. The survey addressed the research questions with primarily close-ended questions with both nominal and interval response options. Some open-ended questions were used for further elaboration and clarification.

This study explored the presence of available services in the nursing home setting that have the objective of maintaining spouse and partner relationships among residents who have a spouse or partner. In this study, a marital relationship is defined as a union between two individuals that is recognized as a legal union in which the couple resides (Merriam Webster, 2020). While marriage may be the official recognition of a spousal relationship, it is important to also consider the bond between two individuals who are not married but are involved in a

romantic relationship with one another. Therefore, this study considers the importance of both spousal and partner relationships.

### **Sample and Procedure**

All facilities certified by the Centers for Medicare and Medicaid Services (CMS) in the states of Alabama, Georgia, Mississippi, and Tennessee were included in the study. CMS is a federal organization that provides a set of rules and protocols that nursing home facilities must adhere to in their day-to-day operations. In exchange, certified nursing home facilities are able to continue receiving funds from the organization through the provision of resident care. In 2014, there were 15,634 nursing homes in the U.S. (Centers for Medicare and Medicaid Services, 2015). Certified nursing homes receive funding for services provided to residents from CMS and therefore must abide by the practice protocols and guidelines outlined by CMS, which include promotion of psychosocial well-being. Each facility must also adhere to guidelines regarding social work staffing. These CMS requirements are recognized on a national level and, therefore, facilities in every state must operate in a similar manner.

Because social workers are the professionals with primary responsibility for addressing the psychosocial needs and well-being of nursing home residents, they are the best informants for this study. The sampling frame included licensed social workers, including social service directors, employed at CMS-certified nursing home facilities located in the states of Alabama, Georgia, Mississippi, and Tennessee. The position/title as social service director is one that the 'lead' social worker in a facility typically holds. In facilities with more than 120 residential beds, CMS requires that the facility employ a licensed social worker, Bachelor's or Master's level. If

the facility employs more than one social worker, one may serve as the social service director and others may be otherwise designated as 'lead social worker.'

As of January 2020 there were 234 certified nursing homes in the state of Alabama comprising just under 1.5% of all nursing homes in the U.S. (Alabama Department of Public Health , 2020). The state of Georgia contains a slightly greater number of certified nursing homes, with a total of 352 facilities (Georgia Department of Community Health , 2020). Georgia facilities make up approximately 2.25% of all nursing home facilities in the United States. Mississippi has 204 certified nursing home facilities comprising approximately 1.2% of all nursing homes in the United States (Mississippi Department of Health, 2019). Additionally, the state of Tennessee houses 319 nursing home facilities making up approximately 2% of nursing homes in the United States (Tennessee Care Planning Council, 2012).

A power analysis was conducted to identify an appropriate sample size as a "best practice" guideline for a quantitative survey. The power analysis determined that a minimum sample size of 45 participants will provide a confidence level of 95%, representing the likelihood of not committing a type I error. Since online surveys often have low participation rates, 225 potential respondents were invited to participate so that the target sample size was reached with a response rate of 20% (Blair et al., 2014). Respondents were given the option to participate in a qualitative phone interview. Telephone interviews were conducted with ten participants who expressed an interest.

### **Recruitment Strategy**

The Alabama Department of Public Health (ADPH) website provides a nursing home directory that lists information about each nursing home in the state of Alabama. This website has a total of 234 facilities listed. Of 234 nursing homes in the ADPH directory, seven of the

listed facilities are designated as specialty care facilities and serve a specific population only and/or do not receive funding from CMS. For this reason, these seven facilities will not be included in the potential list of facilities. Therefore, the sample will be drawn from a total of 227 facilities.

Because target respondents are to be nursing home social workers, facilities with 120 beds or more will be automatically included in the sample for this study for a total of 106 facilities. Even though facilities with fewer than 120 beds are not required to employ a full-time social worker, they are still required to provide social work services in some manner (Social Work Policy Institute, 2010). In an effort to increase the sample size, facilities housing less than 120 beds were contacted to inquire about the presence of a licensed full-time social worker in the facility. A total of 121 facilities in the state of Alabama with less than 120 beds were contacted. Each of these facilities was contacted using the script in Appendix B. Twenty-eight facilities reported that their facility has a full-time licensed social worker on staff, while 55 facilities reported not staffing a licensed social worker. The remaining 38 facilities did not provide a response. Therefore, a total of 134 nursing home social workers in Alabama will be included in the sample for this study.

In additional efforts to reach the desired sample size of 225, certified nursing homes with 120 beds or more in the states of Georgia, Mississippi, and Tennessee were also included in the final sample. In Georgia 117 nursing home facilities have at least 120 beds and in Mississippi 58 facilities fall into this category. Additionally, in the state of Tennessee 138 nursing home facilities housed more than 120 beds. In summary, all licensed social workers identified in the state of Alabama will be included as well as all licensed social workers employed at facilities

with more than 120 beds in Georgia, Mississippi, and Tennessee, for a total of 447 potential respondents.

Each identified facility was contacted to identify the name and email address of the social services director or lead social worker (See Appendix C). Facilities were contacted between the dates of July 9 through July 28, 2020, using the phone number listed on each respective state's health department website. Upon making contact with each facility, the researcher asked to be transferred to social services, after which the researcher attempted to obtain the potential respondent's name and email address. Collected names and email addresses were kept in a password-protected Microsoft Excel document and stored using the UA Box system.

The names and email addresses of interested participants were collected at facilities in all four states. A total of 95 names and email addresses of social workers were collected in Alabama. Additionally, 73 were collected from Georgia, 36 from Mississippi, and 60 from Tennessee. Therefore, the survey was distributed to a total of 264 nursing home social workers.

### **Study Procedures**

Potential respondents received an initial email correspondence through the Qualtrics system that introduced the study, explained the purpose, and solicited participation. This initial email also contained an active link to the survey. Respondents were then able to "click" on the link to begin the survey.

The first page of the survey contained a cover letter that explained the purpose of the study and other elements of informed consent for human subjects in research studies, including assurance of confidentiality and voluntariness of the study. Respondents consented to participate by 'clicking' on an agreement button confirming that they understand the information in the cover letter and agree to participate. Respondents also had the option to start the survey, leave it,

and return at a later date and time to complete the survey within seven days of their initial start date.

Data collection from the survey took place for a total of eight weeks. Initial emails were sent to respondents based on their state of practice as soon as contact information was obtained. Two weeks after the first email requesting participation, a follow-up email was sent to respondents. This follow-up email contained the same information as the initial email, including the survey link. A similar final follow-up email was sent three weeks after the initial invitation. Potential respondents may have received a total of three email requests to participate (one initial, two follow-up reminders). The survey was administered through an online survey platform called Qualtrics. This automated survey administrator sent out all participation emails and follow-up reminders. Follow-up emails were only sent to respondents who had not completed the survey at the time the reminder email was sent.

A total of 264 survey invitations were emailed to potential respondents. The survey was either started or completed by a total of 110 respondents for an initial response rate of 41%. However, 29 survey responses were removed due to completion rates that were less than 30%. The remaining 81 responses were used in the final sample for a final response rate of 30%.

At the end of the survey, participants had the option to provide their contact information for participation in a telephone interview. A total of thirty-four respondents completed this portion of the survey, providing their contact information for a subsequent interview. Ultimately ten respondents were chosen to participate in a telephone interview. These ten were chosen based on several variables with respect to state of practice, number of beds in facility, and gender to obtain a diverse sample. Potential interview participants were contacted via email (See Appendix E). This email contained information about potential dates and times of interviews in addition to

a copy of the interview consent form to be returned to the researcher after completion.

Interested participants returned a completed consent form via email and identified the best date and time for an interview to take place. Approval of the University of Alabama's Institutional Review Board (IRB) was obtained for the study procedures and instrument prior to beginning the study.

### **Study Incentives**

No monetary incentive was offered to survey respondents. However, respondents who volunteered and were selected to participate in a telephone interview received a \$10 Amazon gift card. Additionally, all survey respondents and interview participants received a summary of the major findings of the study.

### **Measures**

The survey instrument (Appendix H) and the interview guide (Appendix I) were designed specifically for this study. No existing instrument was located in the literature that could address the research questions. Policies and practice guidelines regarding interdisciplinary teamwork from the Centers for Medicare and Medicaid Services State Operation Manual (Centers for Medicare and Medicaid Services, 2017) provided initial guidance in the development of the survey. This manual outlines the responsibilities and purpose of the interdisciplinary team in the nursing home setting. The NASW's Standards for Social Work Practice in Long-Term Care and the NASW's Standards for Social Work Practice in Health Care Settings provided additional guidance in survey development, outlining the responsibilities of social workers in long-term care settings (National Association of Social Workers, 2003; National Association of Social Workers, 2016). The existing research in areas closely related to couplehood in the nursing home were also useful in designing the instrument. For example, questionnaires from previous studies

exploring staff attitudes related to intimacy in the nursing home setting guided the development of questions concerning staff perceptions of intimate expression and staff attitudes regarding service delivery in this area. The researcher's experience as a nursing home social worker in direct practice also contributed to the development of the specific survey items.

The survey was composed of four domains: 1) Facility Policies and Services Provided to Preserve Resident Spousal and Partner Relationships; 2) COVID-19 Pandemic Services and Facility Restrictions; 3) Facility Routine Practices and Demographics; and 4) Social Workers' Background Information: Professional and Personal. The first domain, Facility Policies and Services Provided to Preserve Resident Spousal and Partner Relationship, contained questions related to each facility's policies and programs regarding residents who have a spouse or partner. This domain was composed of 25 questions. Eleven items collected categorical data and included an "other, please specify" option to allow respondents to add a specific response if theirs does not "fit" into any of the listed categories. As an example, for the question "What type of accommodations or services are included in your facility's written policy?", respondents were able to choose from these categories: "Private space accommodations for resident and spouse to visit"; "Private meals or dinner accommodations"; "Couples activities"; "Couple outings"; "Other (please specify)"; and "No special accommodations." Seven questions in the first domain were all open-ended. Open-ended questions in this section allowed respondents to provide specific information about their facility's policies and programs. For example, a question in this section asked "Within your facility's organized activities program, what type of activities might serve to preserve spousal or partner relationships between residents and their spouse or partner?". Other open-ended questions in this section required a numerical response. For example, "Currently, how many residents in your facility share a room with their spouse or partner?".

Because this section asked respondents to provide information related to their duties and tasks, seven questions in this section contained responses that were measured on an interval level. Ordinal responses provided respondents with an opportunity to score the frequency of their participation in certain facility functions. For example, a question read, "During your workday, how often do you communicate with other team members about residents' psychosocial needs?". Respondents identified on a scale of 0 to 10 how often they participate in the identified tasks. In the interval response options, 0 suggested the lowest frequency, while 10 suggested the highest level of participation.

COVID-19 Pandemic and Facility Restrictions is the second domain in the survey. This domain was composed of a total of 11 questions. In March of 2020, in response to the spread of COVID-19, the Centers for Medicare and Medicaid Services (CMS) and states enacted new visiting, screening, and activity procedures. CMS put into place the following restrictions and guidelines:

- Restricting all visitors, effective immediately, with exceptions for compassionate care, such as end-of-life situations;
- Restricting all volunteers and nonessential health care personnel and other personnel (i.e. barbers);
- Canceling all group activities and communal dining; and
- Implementing active screening of residents and health care personnel for fever and respiratory symptoms (Centers for Medicare and Medicaid Services , 2020).

Because these restrictions and guidelines directly influenced nursing home residents' ability to visit and interact with their loved ones and to capture data about this historical event as it affects relationships, questions related to the COVID-19 restrictions were included in both the

survey and the interview protocol. This domain was composed of a total of 11 questions. The COVID 19 section of the survey contained questions about each participant's facility policies and practices during the COVID-19 pandemic. Eight questions in this domain allowed respondents to select a response from various nominal options. For example, in answering the question "Did/Has your facility made any exceptions regarding visitation for residents who have a spouse that lives in the community?", respondents were able to choose from nominal categories "Yes"; "No"; "I Don't know"; or "Other, please specify." Three questions in this domain were open-ended. One question asked "What kind of visitation was allowed for spouses or other family members for residents who were actively dying?" Respondents were asked to describe their facility's visitation procedures for this situation.

The third domain, Facility Routine Practices and Demographics, included descriptive questions about the respondent's facility. This domain contained a total of eight questions. Two questions in this domain were measured on a nominal level, with the remaining four requiring an open-ended response. One question asks, "In which type of community is your facility located?". Respondents were able to choose from the following: "Large Metropolitan"; "Small Metropolitan"; "Rural or Small Town"; "Suburban area"; and "Other (please specify)". Open-ended questions in this section required numerical responses related to caseload, social work staffing, and facility capacity. For example, respondents were asked to identify their average weekly caseload. Six questions in this domain required an open-ended response.

The fourth and last domain focused on obtaining information about the respondent's professional and personal background. This section contained a total of nine questions, five of which included nominal category responses and the remaining four were open-ended. One of the nominal questions in this category asked respondents to identify their highest level of education.

Respondents were able to select “Bachelor’s degree”; “Master’s degree”; “Ph.D./DSW”; or “Other, please specify.” Open-ended questions in this section asked respondents for numerical data. For example, one question asks, “How many years have you been practicing social work in the nursing home setting?”. Table 1 provides a listing of each survey item corresponding to each research question. At the end of the survey, respondents were given the option to participate in a telephone interview by inserting their contact information for future contact.

The interview guide for this study contained a total of nine questions. Each question was taken from at least one of the domains outlined in the study’s survey. Interview participants were asked to provide information about their duties and responsibilities in their facility, relationship maintaining practices, ideal relationship maintaining the program, and COVID-19 restriction practices. See Appendix I for the full interview guide.

### **Instrument Pre-Testing**

After survey development, pre-testing was obtained with four nursing home social workers. These social workers were selected from facilities that had more than one social worker within the identified states. The pre-test was administered under the same conditions that potential participants would experience. This included receipt of the same invitation to participate email that was received by respondents. Pre-test invitation emails were also administered via Qualtrics.

Following the completion of pretests, each pretest respondent was contacted by the researcher via phone to answer questions regarding clarity of questions, time of completion, and additional suggestions. One pre-test respondent suggested the use of a shorter consent form, however, the consent form was not able to be shortened because of the requirements of UA IRB. Pre-test participants reported a completion time of around 20 minutes if the survey was

completed in one sitting. The pre-test data were not analyzed in determining results but were only used to refine the survey.

### **Validity and Reliability**

Because the survey used in this study was created specifically for this study, it is not possible to have it tested for reliability. However, the survey was pretested with four nursing home social workers to provide some face validity. Pre-test participants were asked for feedback regarding item clarity, item relevance, estimated completion time, and other changes that would improve the survey.

### **Trustworthiness**

The interview protocol was created specifically for the proposed study. Efforts to ensure quality and trustworthiness were implemented. Triangulation was used in this study as data collection took place using multiple methods (quantitative and qualitative) to provide corroborating evidence (Creswell & Poth, 2018). From a participant's lens, member checking was used to obtain feedback from all interview participants. These participants were emailed a summary of the major themes identified following the analysis of interview data. Participants were asked to respond to the following questions:

- Is any information missing from the analysis?
- Do you have any additional thoughts regarding this analysis?

The above questions allowed participants to judge the accuracy of the information provided through the interview sessions. Eight of the ten interview participants provided feedback for the member-checking process. All of these participants thought that the identified themes were accurate and had no additional suggestions. Lastly, thick description will be used to allow readers of the study results to transfer information to other settings (Creswell & Poth, 2018).

## **Data Analysis**

Data analysis was guided by each research question and survey item. Questions that collected quantitative data were analyzed with descriptive statistics including percentages, means, and frequencies. Data analysis highlighted common practices within each represented facility.

Responses from open-ended items were analyzed using various techniques. For open-ended items that requested numerical responses, the average for each of these items was calculated and is presented in the Results section. Additionally, open-ended questions that required the entry of nominal data were analyzed by categorizing data. For example, respondents were asked to insert their highest level of licensure. For this item, five categories were created: Clinical, Master's, Bachelor's, and Other. Responses were then separated into the appropriate category. Additionally, questions containing an "other, please specify" option were also analyzed to incorporate "other, please specify" responses. This was done by categorizing "other, please specify" responses into the appropriate category if already listed or creating a new category if the inserted response was not listed. For example, participants were asked to identify activities in which residents were likely to participate. This survey item contained several common activities for respondents to choose from in addition to an "other, please specify" option to allow participants to provide relevant responses that were not listed. For this survey item, if a participant selected "other, please specify" and typed in "Monopoly" this response was added to the frequency total under board games. However, if a participant typed in a response that was not listed a new category was created. Results from survey responses are displayed using graphs and tables as appropriate to aid in the examination of findings.

Semi-structured telephone interviews were conducted with participants who expressed interest in participating in the interview portion of the study. Interviews were conducted via telephone and voice recorded. Each interview was transcribed and analyzed using N-Vivo. Provisional coding occurred the first cycle of analyzing. This type of coding utilizes researcher-generated predetermined codes to apply to data (Miles et al., 2020). Provisional codes reflected each of the interview questions. In addition, sub-coding was used to further analyze and identify common themes within each provisional code. For example, participants were asked to identify possible components of an ideal program. For this item, “ideal program” was identified as a provisional code. Ideal program was further analyzed to identify common ideal activities or services suggested by participants. For example, “specific activities for couples” and “supportive services” were mentioned by participants and were therefore identified as sub-codes for the analysis portions of this study.

### **Software Use**

This survey was administered online through Qualtrics web-based platform. This program tracked respondent participation and sent out invitations and reminders to respondents. The Descriptive data was generated utilizing the data analysis feature in Qualtrics. Qualtrics is licensed and available through The University of Alabama and is recommended/approved for research for faculty and students by the UA IRB. Semi-structured interviews were transcribed and entered into N-Vivo for a deeper analysis of interview responses. N-Vivo is also available through The University of Alabama.

### **Institutional Review Board Considerations**

An application outlining this study’s methods was submitted to the University of Alabama’s Institutional Review Board on May 25, 2020. The application included study

protocols, informed consent, and copies of email notifications. The study was approved on July 6, 2020. A copy of the IRB approval letter is located in the appendix (Appendix J).

### **Risks and Benefits of the Study**

The potential risks to study respondents were minimal. All of the respondents were professional nursing home social workers and, therefore, not a part of a vulnerable population. Based on the content of the survey items, no psychological or emotional distress was expected while or after taking the survey. Although respondents provided information related to facility services and staff training, there were no professional or employment risks for participants because no identifying information was collected for survey respondents and the identities of interview participants were de-identified. As a benefit of the study, all respondents will receive a summary of the study's major findings.

## CHAPTER 4

### RESULTS

The purpose of this study was to examine the services and/or programs nursing home facilities use to preserve relationships between residents and their spouses or partners. The research questions for this study were addressed through a quantitative survey and semi-structured interviews. A total of 81 nursing home social workers completed the survey and ten of these respondents also completed the interview portion of the study. Interviews with nursing home social workers were conducted to gather detailed information about the research questions. The survey results provide background demographic information about respondents and characteristics of the facilities in which they are employed. This section includes the results of the survey items that correspond with each of the research questions responses to interview questions as well as the data and descriptive identified themes that will describe the interview content themes.

#### **Quantitative Results**

##### **Respondents' Demographics and Facility Characteristics**

Table 1 provides information about respondents' gender, race, and age. Most survey respondents were female. Additionally, the highest percentage of respondents identified as Caucasian (non-Hispanic). The ages of the respondents varied between 35-71, with the largest respondent group in the 35-45 age range; the number of respondents within the ranges of 46-56 and 24-34 were not far behind.

Table 1

*Respondents' Demographics*

| Variables                      | <i>n</i> | %    |
|--------------------------------|----------|------|
| Gender                         |          |      |
| Female                         | 70       | 87.5 |
| Male                           | 10       | 12.5 |
| Race                           |          |      |
| Caucasian, non-Hispanic        | 56       | 71.8 |
| African American, non-Hispanic | 19       | 24.3 |
| African American, Hispanic     | 2        | 2.6  |
| Native American                | 1        | 1.3  |
| Age                            |          |      |
| 24-34                          | 21       | 26.6 |
| 35-45                          | 28       | 35.4 |
| 46-56                          | 22       | 27.8 |
| 57-71                          | 8        | 10.2 |

*Note:* Due to missing data the total *n* available for each item varies: gender *n*=80; race *n*=78; age *n*=79

Recruitment for the sample for this study included social workers in nursing homes in the states of Alabama, Georgia, Mississippi, and Tennessee. Table 2 provides an accounting of respondents' states. The largest percentage were from Alabama, followed by respondents residing in Georgia, Tennessee, and Mississippi.

Table 2

*Respondents' State of Practice*

| States      | <i>n</i> | %     |
|-------------|----------|-------|
| Alabama     | 29       | 35.8  |
| Georgia     | 24       | 29.63 |
| Mississippi | 7        | 8.64  |
| Tennessee   | 21       | 25.93 |

Respondents' highest educational attainment and licensure type varied as well, as seen in Table 3. The largest group of respondents reported a Bachelor's degree as their highest educational level, while Master's degree recipients were less represented. Respondents with a Ph.D. or DSW made up the smallest percentage of respondents.

Table 3

*Professional Education and Credentials*

| Variables                | <i>n</i> | %     |
|--------------------------|----------|-------|
| Highest degree           |          |       |
| Bachelor's degree        | 44       | 55    |
| Master's degree          | 35       | 43.75 |
| Ph.D./DSW                | 1        | 1.25  |
| Social Work License Type |          |       |
| Clinical                 | 5        | 7     |
| Graduate                 | 13       | 18    |
| Bachelor                 | 31       | 42    |
| No license               | 21       | 29    |
| Other                    | 3        | 4     |

*Note:* Due to missing data the total *n* available for each item varies: highest degree *n*=80; social work licensure type *n*=73.

Regarding respondents' facility information, respondents from all states reported varying data about the characteristics of their facilities. Table 4 provides data about the total number of beds in respondents' facilities, current census, CMS certification, and type of community. Most respondents reported practicing in facilities that house between 120 and 219 residents. Additionally, a large portion of respondents reported having a daily census between 20 and 119. Most respondents worked in Medicaid and Medicare certified facilities. Table 5 also shows the type of community in which each respondent's facility is located. Almost one-half of respondents reported working in a facility located in a rural or small town, while a smaller portion reported their facility was located in a suburban area.

Table 4

*Facility Characteristics*

|                          | Variables                       | <i>n</i> | %  |
|--------------------------|---------------------------------|----------|----|
| Total Number of Beds     | 20-119                          | 18       | 22 |
|                          | 120-219                         | 61       | 75 |
|                          | 220-250                         | 2        | 3  |
| Current Census           | 20-119                          | 54       | 68 |
|                          | 120-190                         | 25       | 32 |
| CMS Certification Status | Medicaid and Medicare Certified | 79       | 98 |
|                          | Medicaid Certified Only         | 1        | 1  |
|                          | Medicare Certified Only         | 1        | 1  |
| Type of Community        | Large Metropolitan              | 6        | 8  |
|                          | Small Metropolitan              | 9        | 11 |
|                          | Rural or Small Town             | 49       | 61 |
|                          | Suburban Area                   | 16       | 20 |

*Note:* Due to missing data the total *n* available for each item varies: total number of beds *n*=81; current census *n*=79; CMS certification status *n*=81; type of community *n*=80.

### **Preservation of Spousal/Partner Relationships**

Study respondents were asked to respond to a series of questions related to their facility's efforts to preserve spousal and partner relationships among residents. Table 5 shows participant responses to the presence of a written policy to preserve spouse and partner relationships and barriers experienced in implementing this program. In observing Table 5, about one-half of respondents who answered this question reported that their facility had a written policy that addressed the delivery of services that focused on the preservation of spousal or partner relationships. Of the respondents who reported having a written spousal and partner relationships policy in their facility, a good portion reported no barriers when implementing their facility's policy. The most frequently identified barrier was lack of private space.

Table 5

*Written Policy and Barriers*

|                                 | Variables                          | <i>n</i> | %  |
|---------------------------------|------------------------------------|----------|----|
| Written Policy                  | Yes                                | 26       | 49 |
|                                 | No                                 | 27       | 51 |
| Barriers in Implementing Policy | None                               | 8        | 38 |
|                                 | Lack of Private Space              | 7        | 34 |
|                                 | Availability of Staff to Implement | 3        | 14 |
|                                 | Attitudes of Facility Staff        | 3        | 14 |

*Note:* Due to missing data the total *n* available for each item varies: written policy *n*=53; barriers to implementing policy *n*=21.

Less than one quarter of the respondents reported that their facility has a program that focuses on the preservation of spousal and partner relationships. Correspondingly, other respondents reported not having a program. Among respondents who reported having a program, all reported that they collaborated with the interdisciplinary team in implementing and designing the program (see Table 6).

Table 6

*Facility Programs*

|                  | Variables                      | <i>n</i> | %  |
|------------------|--------------------------------|----------|----|
| Program          | Yes                            | 15       | 22 |
|                  | No                             | 52       | 78 |
| Major Components | Private Time                   | 15       | 54 |
|                  | Private Meals                  | 7        | 25 |
|                  | Counseling or Therapy Services | 3        | 11 |
|                  | Couple outings                 | 2        | 7  |
|                  | Activities for Couples Only    | 1        | 3  |

|                               |                      |    |     |
|-------------------------------|----------------------|----|-----|
| Role of Respondent in Program |                      |    |     |
| Designing Program             | Collaborate with IDT | 15 | 100 |
| Implementing Program          | Collaborate with IDT | 15 | 100 |

*Note:* Due to missing data the total *n* available for each item varies: program *n*=67; major components *n*=28; role of respondent in program *n*=15.

Respondents were also asked to provide information about resident participation in various activities offered by their facility. Responses to these survey items are outlined in Table 7. This survey item contained an “other, please specify” option to allow participants to share activities that were not previously listed in the survey. “Other, please specify” responses that were already listed as an option were added into the total for that specific item. For example, if a participant selected “other, please specify” and typed in “Monopoly” this response was added to the frequency total under board games. However, if a participant typed in a response that was not listed, a new category was created and is presented below. Responses were split into categories of short-term resident participation and long-term resident participation. This was done to identify participation differences based on resident type of stay. However, participation was fairly consistent regardless of type of stay, with activities such as board games, ice-cream socials, birthday parties, musical and religious events, and holiday parties comprising substantial percentages in participation for both short-term and long-term stay residents.

Table 7

*Participation in Facility Activities*

| Activity                     | Short-Term Resident Participation |    | Long-Term Resident Participation |    |
|------------------------------|-----------------------------------|----|----------------------------------|----|
|                              | Frequency                         | %  | Frequency                        | %  |
| Board Games                  | 54                                | 15 | 64                               | 14 |
| Birthday Parties             | 34                                | 10 | 64                               | 14 |
| Ice-cream Socials            | 57                                | 16 | 66                               | 15 |
| Musical and Religious Events | 55                                | 15 | 70                               | 16 |

|                        |    |    |    |    |
|------------------------|----|----|----|----|
| Holiday Parties        | 44 | 12 | 61 | 14 |
| Exercising             | 47 | 13 | 26 | 6  |
| Pet Therapy            | 27 | 8  | 28 | 6  |
| Crafts                 | 25 | 7  | 46 | 10 |
| Field Trips/Outings    | 9  | 3  | 23 | 5  |
| Independent Activities | 2  | 1  | -  | -  |

*Note:* Respondents were asked to select all that applied.

Respondents were asked to provide information about their facility’s activity program as it relates to preserving spousal/partner relationships. Holiday and special event parties were identified more frequently as an activity that might serve to preserve spousal or partner relationships. Music-related activities and visitation were also among the top selected activities that might preserve spousal or partner relationships. Respondents were also asked to identify the number of short-term residents and long-term residents that have a spouse or a partner (see Table 9). Both long-term and short-term residents are more likely to have a spouse who resides in the community than they are to have a spouse who resides in the same facility or with whom they share a room.

Table 8

Activities

| Activities                                  | <i>n</i> | %    |
|---|----------|------|
| Holiday and Special Event Parties (socials) | 25       | 23.4 |
| Musical Related Activities                  | 13       | 12.1 |
| Visitation                                  | 12       | 11.2 |
| Board Games and Crafts                      | 10       | 9.3  |
| Religious Activities                        | 9        | 8.4  |
| Date Night and Couple Outings               | 9        | 8.4  |
| None  | 9        | 8.4  |
| Dinner/Meals                                | 8        | 8    |
| Celebrating Anniversaries                   | 4        | 3.7  |
| Group Work/Therapy                          | 4        | 3.7  |
| Living Arrangements                         | 3        | 2.8  |
| Exercise                                    | 1        | .9   |

*Note:* Respondents were asked to select all that applied.

Table 9

*Facility Couple Characteristics*

|                      | Variables                             | Range   | Average |
|----------------------|---------------------------------------|---------|---------|
| Short-term Residents | Spouse or Partner Resides in Facility | (0-70)  | 2       |
|                      | Spouse or Partner in Community        | (0-100) | 8       |
|                      | Share a Room with Spouse              | (0-15)  | .2      |
| Long-term Residents  | Spouse or Partner Resides in Facility | (0-100) | 4       |
|                      | Spouse or Partner in Community        | (0-100) | 14      |
|                      | Share a Room with Spouse              | (0-15)  | .8      |

*Note:* Due to missing data the total *n* available for each item varies between *n* of 79-81.

Survey respondents were asked to rate the need for relationship preserving services in their facility for both short-term and long-term stay residents. Responses to these questions were gathered by allowing the participant to rate the need for these services on a scale of 0-10. Ratings ranging from 0-3 suggest a low need for services, while 4-6 suggest a moderate need and 7-10 reflect a high need. For short-term residents, approximately 33% reported a low need for services, while 29% and 38% reported a moderate or high need respectively. However, these numbers varied when asked about relationship preserving services for long-term residents. For this item, 77% of respondents reported a high need for services for long-term residents, while 8% and 12% reported a low or moderate need for services. These data suggest that respondents identified a greater need for relationship preserving services among long-term residents than for residents who are residing in the facility for a shorter amount of time.

Respondents were also asked to respond to survey items pertaining to the frequency at which they discussed the preservation of relationships with their residents. Responses for this were also gathered using a scale ranging from 0-10, with 0-3 suggesting low frequency and 4-6 and 7-10 suggesting moderate and high frequency respectively. For this item 34% of respondents reported a low frequency of discussing how to preserve spousal/partner relationships with

residents, while 38% reported moderate frequency of discussion. Twenty-seven percent reported a high frequency of these discussions with residents.

Also respondents were asked to report how frequently they discussed the psychosocial well-being of residents with other members of the interdisciplinary team and with the residents themselves. Using a scale ranging from 0-10, response ratings from 0-3 are interpreted as a low frequency of discussion, while ratings between 4-6 suggest moderate frequency. Ratings higher than 7 suggest a high frequency of discussion. For psychosocial well-being discussions with other members of the interdisciplinary team, 92% of respondents reported a high level of frequency for these discussions, while 2% and 5% reported low and moderate frequencies. Lastly, respondents were asked to provide responses for the frequency of psychosocial well-being discussions with residents. For this item, 89% of respondents reported a high frequency rating, while 11% reported a moderate rating.

### **COVID-19 Restrictions**

Survey respondents were also asked to provide feedback to questions related to their responsibilities and facility practices during the coronavirus pandemic. Regarding facility restrictions during the coronavirus pandemic, changes to residents' visitor schedules was most frequently reported. Suspension of residents' activity programs was also mentioned frequently. A few respondents shared additional restrictions such as changes to facility activity programs (instead of suspension), prohibiting visitation from certain outside agencies but not all, and changes to resident meal settings. Although well over one-half of the respondents reported making no exceptions to coronavirus restrictions, many reported that their facility has made exceptions for residents' spouses or partners regarding visitation. Exceptions were further explored as respondents were asked to share situations in which their facility made visitation

exceptions for spouses or partners. The most commonly reported reason for exception involved situations in which the resident was actively dying. An additional reported exception included a major change in the resident’s medical condition.

Table 10

*COVID-19 Facility Practices*

|                          | Variables  | <i>n</i> | %  |
|--------------------------|--|----------|----|
| Facility Restrictions    | All residents’ visitors were not allowed in the building | 79       | 41 |
|                          | No outside agency personnel were allowed in the facility | 34       | 18 |
|                          | Resident activity program suspended                      | 48       | 25 |
|                          | No restrictions were put into place                      | 14       | 7  |
|                          | Other  | 18       | 9  |
| Exceptions for Residents | Yes  | 26       | 33 |
|                          | No   | 54       | 67 |

*Note:* For facility restrictions respondents selected all that applied; exceptions for resident *n*=80  
 Respondents also provided information about their facility's efforts to maintain social 'connections' between residents and their families and friends (see Table 11). Respondents most frequently reported that their facility organized phone calls, video chats, and visits through a glass door or window. Other responses included practices such as resident use of personal cellphones, videos shared by family, ‘drive-by’ visitations, and socially-distanced outside visits. In addition, over one-half of the respondents reported that their facility did not make any special efforts to facilitate in-person visitations. Those that made special efforts for their residents to participate in in-person visits identified activities such as window visits, allowing visitation if a resident is actively dying, and ‘drive-by’ visits.

Table 11

*Maintaining Social Connections*

| Variables                                  |  | n  | %  |
|--|--|----|----|
| Maintaining Social Connections             |  |    |    |
|  | Organize phone calls between residents and their friends and family members              | 77 | 28 |
|  | Organize and facilitate video chats between residents and their friends and family       | 76 | 28 |
|  | Ensured presence of residents in care plan meetings with family members                  | 31 | 11 |
|  | Allowed residents to visit with friends and family member through a glass door or window | 77 | 28 |
|  | Other  | 13 | 5  |
| Efforts to Facilitate in-Person Visitation |  |    |    |
|  | Yes  | 29 | 36 |
|  | No   | 51 | 63 |
|  | I Don't Know   | 1  | 1  |

*Note:* For maintaining social connections respondent selected all that applied.

The COVID-19 survey section included questions about facility practices specifically for residents who have a spouse or partner. Many respondents shared that spouses and partners were not allowed to visit with one another face-to-face, while a slightly smaller percentage of respondents did not enforce visitation restrictions, and thus allowed spouses and partners to visit with one another as normal. Additionally, many participants shared that their facility currently does not have couples. However a good portion of the respondents identified other facility practices including socially distanced visits, window visits, room arrangement (spouses share a room), and no visits allowed. Table 13 contains information about respondents' opinions on the longevity of COVID-19 related restrictions. Staff screening upon entering the facility was reported most frequently. However, quarantine requirements for new admissions and staff requirements to wear PPE were not far behind. “Other, please specify” responses for this item

included staff education, eliminating semi-private rooms, no long-lasting restrictions, and PPE for isolated residents.

Table 12

*Spouse or Partner Restrictions*

| Restrictions   | <i>n</i> | %  |
|--|----------|----|
| No restrictions-spouses and partners were allowed to visit with one another as usual.  | 20       | 25 |
| Spouses and partners were allowed to visit with one another for only a specified time. | 3        | 4  |
| Close monitoring of residents' spousal and partner visits by facility staff            | 9        | 11 |
| Spouses or partners were not allowed to visit with one another                         | 23       | 28 |
| Other, please specify  | 26       | 32 |

Table 13

*Long-Lasting Restrictions/Policies*

| Restrictions/Policies                                | <i>n</i> | %  |
|--|----------|----|
| Staff requirement to wear PPE such as masks or gowns | 55       | 15 |
| Quarantine requirements for new admissions           | 63       | 18 |
| Visitation Restrictions                              | 44       | 12 |
| More Frequent Vital Checks for Residents             | 49       | 14 |
| Social Distancing During Resident Activities         | 42       | 12 |
| Non-communal Dining                                  | 28       | 8  |
| Staff Screening Upon Entering Facility               | 70       | 20 |
| Other  | 4        | 1  |

*Note:* Respondents were asked to select all that applied.

Respondents were also asked about their role in COVID-19 policies/restrictions and changes in their daily work (see Table 14). Most respondents reported they were not involved in the development of their facility's policies to address the COVID-19 pandemic. Regarding changes to respondents' daily work, a focus on residents' connections with their families was reported most frequently. Providing emotional support for co-workers and assisting with staff screening for COVID symptoms were also often reported. Respondents who selected “other, please specify” shared practices like frequent updates for residents and their families, facilitating

communication between residents and their family members, providing emotional support to residents, and creating virtual activity opportunities.

Table 14

*Social Work Involvement*

| Variables                           |   | <i>n</i> | %  |
|-------------------------------------|---|----------|----|
| Role in Development of New Policies | Solely responsible for the development of written policies                                | 0        | 0  |
|                                     | Worked in conjunction with the interdisciplinary team members to develop written policies | 20       | 25 |
|                                     | Worked in conjunction with Administration to develop written policies                     | 10       | 12 |
|                                     | Not involved at all   | 15       | 63 |
| Changes in Daily Work               | Focus on Resident Connections with Family   | 61       | 20 |
|                                     | Increased efforts to obtain advanced directives for residents                             | 27       | 9  |
|                                     | Conducted discharge planning for residents returning to the community                     | 38       | 12 |
|                                     | Provided emotional support for co-workers   | 41       | 14 |
|                                     | Assisted with disinfecting procedures   | 35       | 11 |
|                                     | Assisted with staff screening for COVID symptoms upon entry into the facility             | 41       | 14 |
|                                     | Conducted in-room activities for residents  | 28       | 9  |
|                                     | Assisted with decision making for admission referrals                                     | 22       | 7  |
|                                     | Other   | 13       | 4  |

*Note:* For development of policy n=45; for changes in daily work respondents were asked to select all that applies.

**Qualitative Results**

A total of ten semi-structured interviews were conducted with survey respondents who expressed interest in participating in the interview portion of the study. Each interview was transcribed and analyzed to identify common themes. Following the analysis of the data,

member-checking also took place, as each participant was emailed the identified major themes.

Participants responded to the following questions:

- Is any information missing from the analysis?
- Do you have any additional thoughts regarding this analysis?

Eight of the ten interview participants provided feedback for the member-checking process. All of these participants thought that the identified themes were accurate and had no additional suggestions.

Each interview was transcribed and analyzed using N-Vivo. Provisional coding was used to analyze qualitative data. This type of coding is utilized during the first cycle of coding in which researcher-generated codes are applied to the data (Miles et al., 2020). For this study, codes were predetermined by the researcher and were based on the interview protocol. During first-cycle coding, information from each interview transcription was applied to each of the predetermined codes. Information in each code was further analyzed during the second cycle of coding to identify common themes within each coded section. Demographic information and themes related to each research question are presented below.

### **Demographic and Facility Information**

Seven out of ten participants were female, while male participants comprised the remainder of the interview sample (see Table 15). The average age of participants was 33, ranging from 25-44. Most participants practiced in facilities located in the state of Alabama, while Georgia and Tennessee practitioners both comprised a smaller percentage of the sample. One participant practiced in Mississippi, making up the smallest percentage. Years of practice in their current position varied greatly from 4 months to 20 years of practice.

Table 15

*Participant Demographic and Facility Information*

| Interviewee | Gender | Age | State | Years of in Current Position |
|-------------|--------|-----|-------|------------------------------|
| 1           | Female | 30  | GA    | 3.5                          |
| 2           | Female | 42  | TN    | 20                           |
| 3           | Male   | 29  | MS    | 1                            |
| 4           | Female | 33  | AL    | 1                            |
| 5           | Female | 40  | AL    | 3                            |
| 6           | Female | 35  | AL    | 7                            |
| 7           | Male   | 28  | TN    | 1.5                          |
| 8           | Female | 44  | GA    | 4 months                     |
| 9           | Female | 24  | AL    | 1                            |
| 10          | Male   | 25  | AL    | 2                            |

Information regarding participants' duties and responsibilities in their facility was also gathered. Discharge planning was the most frequently reported responsibility, with a majority of participants reporting. Additionally, care planning and facility related responsibilities, such as completing grievance or incident reports, were also mentioned by more than one-half of participants. Referrals and providing supportive services were identified by at least one-half of participants. Referral activities might include activities such as involving home health or hospice services and mental health professionals, such as a psychiatrist, to ensure that residents' emotional and psychological needs are met. Supportive services included services to assist with issues related to residents rights, family dynamics, counseling services, and a host of other services that are provided to support each resident and meet their unique needs.

### **Current Policies, Programs, and Practices**

In addressing research question one, participants were asked to share details about their facility's current policies, programs, and/or practices that serve to maintain relationships between residents and their spouses or partners. The most frequently reported practices included: privacy

and room arrangements, encouragement of visits, dining, spouse or partner participation in facility activities, and outings.

### ***Privacy and Room Arrangements***

Many participants stated that their facility ensures that couples have access to privacy, either through room arrangements or private time in another area of the facility. Participants who identified room arrangements and/or privacy shared that their facility makes room arrangements by allowing spouses to share a room if they desire. Residents who have a spouse or a partner residing in the community (outside of the facility), have access to an area for private visitation. They also added that, to further ensure privacy, frequent training of staff to knock before entering a resident's room is utilized. Accommodations for couples who are both admitted but receiving different services, short-term or long-term, and not residing in the same room, are also offered. One participant stated:

We try to make sure that they have privacy. If they're in a private room it's not as much of an issue but if they are in a semi-private and their spouse is in the community, we make every effort to make sure that they have that [privacy] as well.

Another participant shared:

If we have both spouses in the facility, we always give them the option of rooming together. So if that's something that they desire then we always make accommodations to make sure that they're together. For the most part they want to be in the same room, sometimes they don't so we just honor what their wishes are.

### ***Encouragement of Visits***

In consideration of privacy, participants also identified facility visits as a vital component of their facility's program or practices. One participant shared that in their facility there is

"always an open policy for the residents to have visitors and maintain those relationships during in-person visits". Additionally, another participant described their facility's practice related to encouraging participation:

We try to make sure they are involved with each other's care. If they choose to be participating in each other's care plan meetings, if they are able to make decisions for each other then, you know allowing them to make decision about their healthcare and anything related to them. We also like for them to attend activities together, things like that. So we definitely try to nurture the husband and wife relationship even while they are in the center.

### ***Dining***

Dining together was also identified as a component of facility programs and/or practices. Dining accommodations and participation was mentioned frequently by interview participants. These participants shared their facility's' efforts to encourage spousal and partner participation in meals. Additionally, spouses or partners where both parties reside in the facility are also encouraged to dine together if possible. One participant stated, "We allow family members to come and have lunch with the residents. A lot of our residents who have spouses, they do that."

### ***Spouse or Partner Participation in Facility Activities***

Participants also identified spouse or partner participation in facility activities. Several participants stated that this type of participation is strongly encouraged. Facility activities include any activities that are open for participation for all residents. These activities often include board games and crafts, musical events, religious activities, and holiday celebrations. One participant discussed the ways in which their facility facilitates gardening opportunities for their residents. This participant shared:

If they like gardening together, we have rakes that are specifically geared towards residents in wheelchairs. Some of them are able to walk but they are not able to walk by themselves 100 percent of the time safely. We have set up a garden where both of them can work on a garden together. We've done like date night where they can go out somewhere or go shopping together somewhere.

### ***Outings and Facilitating Transportation***

Participants also shared the importance of encouraging outings for couples. In this case, the term "outing" refers to couples spending time outside of the facility together. During this time couples may choose their destination(s), whether that be dinner and a movie or a walk around the building. One participant shared:

We also allow our families to take residents outside as well to visit either on our front porch or we have a patio that is covered that they can take their loved ones out to as well for some fresh air while visiting.

Another participant shared :

We do have outings with the facility van and so we have taken our residents to the circus and invited their spouses to meet us at the event so then they could spend time with our residents.

### **Ideal Program**

Although participants were asked to describe their facility's current program and/or practices, participants were also asked to share their opinion of exactly what an ideal program for the preservation of spousal or partner relationship might look like. A total of four

odes were generated with participant responses. The following practices were recommended by participants as components of an ideal program: specific activities for couples, supportive services, preference of couple, and privacy and room arrangements.

### ***Specific Activities for Couples***

While many interview participants highlighted their facility's efforts to encourage spousal and partner participation in general facility activities, very few mentioned offering couple specific activities in their facility. Items coded in this category included: one-on-one date nights, community outings, and additional opportunities to have alone time together. Specific activities for couples were mentioned by all participants as an important component of an ideal program for the preservation of spousal and partner relationships. One participant described what implementation of these types of activities might look like:

That's another thing, giving them the opportunity to go out. Not just out of their rooms but outside of the walls of the center to actually go out to the community if they are cognitively intact and if they are mentally and physically able to do so. You know go in the community with each other like Walmart or a restaurant. I feel like we should provide opportunities for that because we do that period because the residents can come and go as they please within the Medicare and Medicaid guidelines.

### ***Supportive Services***

Supportive services were identified by one-half of the participants as a possible benefit to an ideal facility program. Supportive services include services that may not be requested by every couple in the facility but are helpful for the maintaining of spousal and partner relationships. These services might include marital counseling, therapy, and transportation services. One participant stated:

In the event they were having some kind of marital issues or needed some kind of support I feel like we should have a marital counselor to come in. People just like to give their hours and time to volunteer with this population for free or for very low cost. So, if we could get somebody on board to want to offer their services to them related to that, I think that would be great. I would start with that. If the program entailed at least those few things I think it would be great.

### ***Preference of Couple***

Some participants had difficulty identifying activities to include in an ideal program. Instead, these participants stressed the importance of gaining a better understanding of exactly what activities each specific couple would like to have offered to them. Five of the ten interview participants took this approach in their response. One participant discussed the use of a survey upon admission to obtain couples' preferences. This participant stated:

Give them a survey to help us gear the program towards them. I would probably have each couple do a survey of activities they would like to do. Maybe we could try to gear the program based on their needs. Whatever we are able to accommodate.

Another participant stated:

When someone admits to us, we try to get their preferences. Do you want to sleep late? Do you like to sleep in? If we can dig a little deeper into, as a husband or wife, what were things that you and your spouse did and are they things that you would want to continue here? How can we adapt that into this environment.

### ***Privacy and Room Arrangements***

Privacy and room arrangements were identified as a barrier to implementing services. Therefore, it is no surprise that one-half of interview participants also identified it as a vital

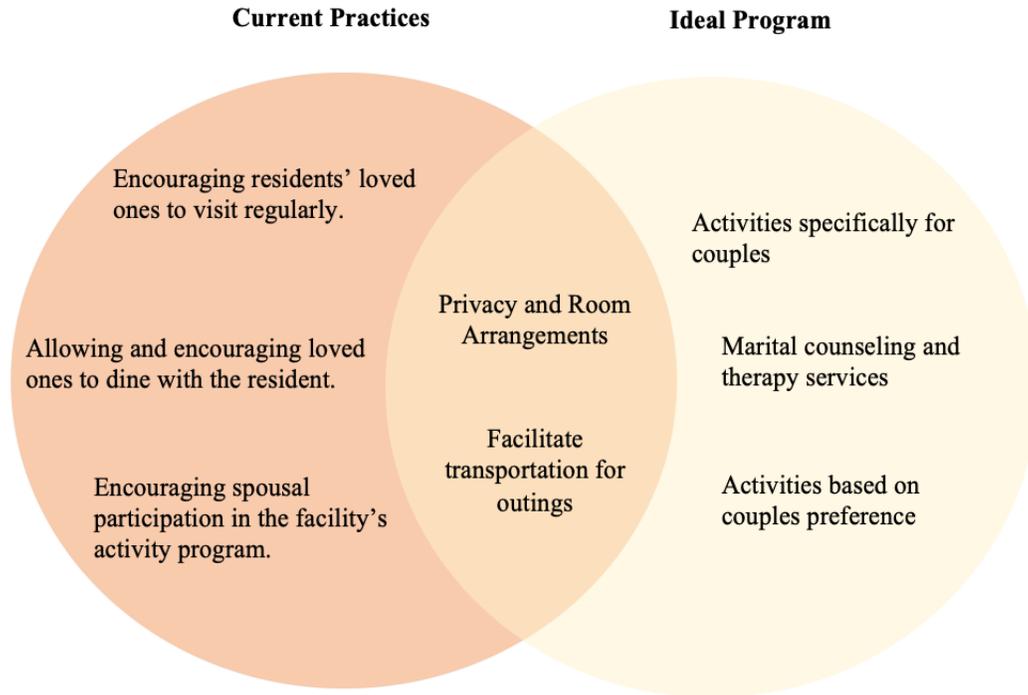
component of an ideal program. Privacy includes encouraging one-on-one time between residents and their spouse or partner. Privacy might also be facilitated through room arrangements by allowing residents who have a spouse or partner residing in the facility to share a room if they desire. Several participants discussed the importance of private one-on-one time and room arrangement accommodations. One participant discussed accommodations like “Pushing the beds together if they want them together.” Another participant emphasized the importance of privacy stating, “I feel like we should give them the opportunity to have more alone time outside of their rooms.” Another participant shared concerns regarding privacy and the importance providing privacy for residents to visit with their loved one:

I think definitely having a private space for people to visit is ideal. I guess if we had unlimited funds that would be different. Having someone available that could help accommodate the needs. Making sure there is always a space available for couples. Always having one vacant room. Some SNFs have co-occupancy. I think if someone wants to conjugate I feel like that’s very difficult and I feel like they should still have that right.

Figure 1 compares participants’ current practices to activities and tasks that participants identified as components of an ideal relationship-preserving program. Participants identified privacy and room arrangements and facilitating transportation for outings as both current practices and practices that should be included in an ideal relationship enhancing program. Participants identified encouragement of regular visits, dining together, and participation in facility activities as current practices, however these items were not highlighted as necessary components of an ideal program. Additionally, identified ideal components included activities

specifically for couples, marital counseling and therapy services, and activities based on couples' preferences.

**Figure 1: Comparison of Current and Ideal Practices**



### **Barriers to Services**

Addressing research question 1, interview participants were also asked to share any barriers they face in implementing the facility's program and/or practices. Participants provided an array of responses to this question. Identified barriers included: privacy and room arrangements, family dynamics, cognitive capacity, ability to visit, and staff attitudes.

#### ***Privacy and Room Arrangements***

Although privacy and room arrangements were the most frequently reported component of facility programs and practices, it was also the most frequently reported barrier with one-half of participants sharing that privacy is an issue in their facility. Several participants mentioned the

issue of privacy in their discussion of room arrangements. This was particularly relevant when sharing facility attempts to facilitate alone time for residents who reside in semi-private rooms. Additionally, participants discussed a lack of facility space or vacant rooms to facilitate a private area for visitation, specifically in cases where the resident's spouse or partner resides in the community. One participant stated:

If one of them has a friend, another male friend, or another female friend, privacy would probably be difficult to maneuver. I feel like privacy would be number one whether it be staff coming in or other residents visiting and stuff like that.

Another participant also expressed concerns related to privacy and residents' rights. This participant shared, "sometimes it can be more difficult to make sure that they have the privacy that they may want just because we don't want to infringe on the other resident's rights who shares the room with them."

### ***Family Dynamics***

Family dynamics were identified as a barrier to providing relationship preservation services by several interview participants. Family dynamics refers to "patterns of interactions among relatives, their roles and relationships, and the various factors that shape their interactions" (Jabbari & Rouster, 2020). In the nursing home setting family dynamics may influence a couple's ability to participate in relationship maintaining services offered by the facility, further becoming a barrier to service provision. In discussing this matter, one participant stated:

Outside family members, because both the parents may be here and the kids feel like they should be in control. It's almost as if they feel like because they are both in the center, the children feel like they are the decision-makers automatically even when one parent or

both of the parents are cognitively intact and still able to make the decision for themselves or each other.

One participant also shared the presence of family dynamic problems concerning interactions between the resident and their spouse or partner. This participant stated:

From a psychosocial perspective too of course are things like dementia. A lot of our residents have issues with dementia. So they don't always know their loved one anymore, or if they have had any issues in the past. Like if the loved one had an affair when they were in their 30's and 40's sometimes those kinds of things will resurface again.

### ***Cognitive Capacity***

In describing barriers to implementing their facility's program or practices, participants also identified the cognitive capacity of the resident as a barrier. Alzheimer's type dementia affects 47% of nursing home residents in the U.S. (Harris-Kojetin et al., 2019). In the discussion of barriers, several participants expressed the issue of cognitive capacity and the ability to consent to physical intimacy. Cognitive capacity was mentioned by three interview participants. As one participant stated, "One thing, especially with the spouse being outside, it really gets a little tricky especially when dementia comes into play with them having sexual intercourse. If they are both alert and oriented, they still can."

### ***Ability to Visit***

Participants also discussed the influence the ability of one or both spouses or partners plays in participation in the facility's program. This barrier was often mentioned in the participant's discussion of residents who have a spouse residing in the community and was identified by several participants. Factors such as one or both spouses or partner's physical ability

and one spouses or partner's place of residency. One participant shared the following on the topic:

Sometimes it's a barrier if the spouse is not home but is in a nursing home or assisted living. Sometimes it's difficult to coordinate things when the spouse is in the community in those settings because you have to go through their staff, it's a little bit of red tape sometimes. Then you have to work around the schedule of the assisted living and work around our schedule.

Another participant shared the influence of a resident's physical ability to participate in certain activities stating:

“The only thing that could have been a barrier would be the resident's ability to ambulate or transfer from a chair to a car to a restaurant chair. Just mobility things that would just be the physical limitation of the resident.

### ***Staff Attitudes***

One participant explained the role that staff attitudes play in carrying out their facility's program. The influence of staff attitudes on intimate expression among nursing home residents has been discussed in previous literature in this area (Helen, 1995; Simpson et al., 2018; Walker & Ephross, 1999; Roelofs et al., 2015). This participant shared:

People not realizing that old people have sex and having to put aside any preconceived notions like they are people, they have desires, and they are married. It's a culture of old people don't do that. That's nasty. Well, they do.

### **Organized Activity Program**

Interview participants were asked to share their opinions about activities within their facility's activity program that might assist in maintaining spousal or partner relationships, even

if the activity was not created for this purpose. Identified facility activities included: crafts, games, and religious activities; special events and celebrations; and dinner and/or movies.

### ***Crafts, Games, and Religious Activities***

The most commonly mentioned activity by interview participants was crafts, games, and religious activities. Participants identified the benefits of activities like bingo, arts and crafts, gardening, workouts, and attending religious ceremonies in preserving relationships among residents who have a spouse or partner. One participant expressed that "sharing a bingo card through playing bingo or helping each other with activities" might help to preserve spousal or partner relationships among residents. One participant shared an instance where activities played a role in developing a relationship between two residents. This participant shared:

We do workouts with our residents and there's a couple of them that just automatically, they were not a couple before they came in here, have become a couple since they have been in here. Watching them do those exercises together is pretty fun to watch. So having ways for them to be active with one another I think is important because it just makes them feel young again.

### ***Special Event and Celebrations***

Special events and celebrations include activities like holiday and birthday celebrations, ice-cream socials, anniversary parties, musical events, and other special occasions. Interview participants described their facility's efforts to constantly encourage family participation in these events which further provide an opportunity for couples to share special time. One participant described their facility's practice for these types of events:

Our special occasions so we do a monthly birthday party and spouses are welcome to come to that party. We do an annual Thanksgiving dinner and we usually have a band or

some sort of entertainment and we send an invite out to family members for that. And then also for Christmas we do a special party for that and family members usually participate.

### ***Dinner and/or Movies***

The last code for general facility activities is dinner and movies. Dinner and movies were mentioned by one-half of interview participants. Participants discussed encouraging spouses and partners to participate in mealtime, whether that be breakfast, lunch, or dinner. Participants also discussed the role that the showing of movies might play in preserving these relationships. Although all residents are invited to participate in meals and movies, the participation of residents' family members provides additional opportunities for relationship maintenance. One participant described the types of movies that might be appropriate. This participant stated, "Movies they would have watched and not things that we watch now in 2020 but things they would remember and kind of rekindle some laughs and things for them."

### **Coronavirus Pandemic**

Participants were also asked to share information about the facility restrictions put into place as a result of the coronavirus pandemic. Because these restrictions and guidelines directly influence nursing home residents' ability to visit and interact with their loved ones, questions related to the COVID-19 restrictions were included in both the survey and the interview protocol. Interview participants were asked to provide feedback on the impact of the COVID-19 restrictions on spousal or partner relationships. Participants were also asked to share their facility's efforts to mitigate the effects of these restrictions.

### ***Impact on Spousal and Partner Relationships***

In describing the impact of the COVID-19 restrictions on spousal and partner relationships, all ten interview participants stated that the restrictions have had a negative effect not only on resident relationships with their spouse or partner but their mental health as well. Participants shared their observations of mood changes, physical decline, and difficulty coping with the death of a spouse during the pandemic. One participant also reported an increase in the prescribing of antidepressants since the COVID-19 restrictions were put into place. Another participant shared a vivid description of the impact of these restrictions on a particular resident in their facility and their community-dwelling spouse.

It's affected them greatly. Even with the spouses that are in the community that has a wife or a husband here that can't see them as much and can't talk to them as often, they have to rely on staff. Sometimes they are in therapy and are not able to answer their phone as much. They are having to see them through a window right now. It's just not the same. It's affected them greatly. I think of one little elderly guy who comes every day to see his wife through the window. He's constantly asking when can I come in. It's having a huge impact on their relationship. And just their mental health. It's almost breaking their bond.

### ***Mitigating Practices***

Participants also shared their facility's practice techniques to preserve residents' relationships with their loved ones during the COVID-19 pandemic. The most frequently mentioned mitigating techniques were video calls and window or plexiglass visits. Participants whose facility utilized video calls during the pandemic mentioned the use of Skype, Zoom, and FaceTime to facilitate these calls. One participant described how their facility organized window visits, stating:

Window visits where there is a sitting area for the family in front of the window and there is a sitting area for the resident and there is a phone that connects them. We can put it on speaker, or we can hold the phone, so you don't have to use your cell phone and the landline connection is a little better that way. So they can see each other through the window.

Additional mitigating techniques included in-room activities and encouraging residents to speak with their loved ones via phone as much as possible. Due to COVID-19 restrictions, nursing homes were no longer able to have group activities or communal dining. As a result, nursing homes were forced to make changes to the way activities were carried out in the facility. For example, one participant reflected on their facility's efforts in this regard, stating: “We amped up some of our activities but it would have to be room to room. We would do homemade ice cream and make non-alcoholic margaritas. Just little things to pass from room to room.”

## CHAPTER 5

### DISCUSSION

This study examined services and/or programs that nursing home facilities use to preserve relationships between residents and their spouses or partners. Notable findings from both quantitative and qualitative data are discussed in this chapter. Implications for social work as well as study strengths and limitations are also presented.

#### **Services and Programs to Preserve Spousal Relationships**

The nearly even split between survey respondents who reported having a written policy and those who did not suggests that an awareness of services for spouses and partners is present. Despite this split, the assumption cannot be made that nursing homes without a written policy are unaware of this need, nor does this suggest that relationship preserving services are not present in the absence of a written policy. All respondents identified various practices that their facility uses to help residents and their spouses or partners maintain their relationships. Practices such as ensuring privacy upon request, honoring requests for a couple's room arrangements (living together in same room at facility), arranging for use of private space and facilitating outings are all beneficial to the preservation of these important relationships.

Additionally, most respondents reported not having a facility program dedicated to the preservation of relationships between residents and their spouse or partner. In this regard, it is important to recognize the relationship between a written policy and a program. The term policy is defined as a "system of principles to guide practices with the purpose of achieving a certain goal" (Merriam-Webster, n.d). On the other hand, the term program refers to "a plan or system

under which action must be taken toward a goal” (Merriam-Webster, n.d.). This means that a program outlines the steps to implement a particular policy and to ensure adherence to the principles outlined in the policy. In consideration of this information, coupled with significantly more respondents who reported having a written policy than those who reported having an actual program, additional exploration and conversations must take place. It is apparent that many nursing homes have a written policy, whether it is adopted from CMS guidelines or created specifically for a particular facility. However, a deficit is present related to the presence of formal programs to meet the goals of these written policies. This brings to the forefront a possible need to take written policies in this setting a step further by providing step-by-step guidance for nursing home staff to utilize when tending to the psychosocial needs of their residents. This is especially important in consideration of attachment theory and its emphasis on the effects that threats to important relationships might have on residents’ overall psychosocial well-being. While establishing a written policy to preserve these relationships is an essential step in maintaining spousal and partner relationships, programs may also be helpful in providing step-by-step guidance to facility personnel to ensure the maintenance of residents’ attachment with their spouse or partner.

### **Privacy in the Nursing Home**

The most commonly mentioned practice among both survey and interview participants was privacy and room arrangements for couples. These findings are consistent with past research in this area (Doll, 2013; Cornelison & Doll, 2013; Simpson et al., 2017). Despite the efforts being made to preserve privacy in nursing home facilities, privacy and room arrangements were

also identified as barriers to service provision. In fact, this was most commonly discussed among interview participants. Participants shared that they experienced problems with providing residents and their spouses or partners with a private area within the facility to have time alone. This was a particularly significant problem in situations in which a resident resides in a semi-private room but their spouse or partner resides in the community. In these situations, participants expressed difficulty finding private space. This is often due to physical limitations of the resident's roommate. For instance, many nursing home residents experience physical limitations, such as inability or difficulty walking, and are therefore not always able to provide private time to their roommate and his or her spouse or partner. Limited private areas are also a concern when facilities do not have empty rooms to facilitate this private time for couples. However, participants shared that privacy was less of an issue when the couple resided in the same facility and/or room.

The identification of privacy and room arrangements as key components of nursing home programs and also the primary barrier to implementing these programs is worth highlighting. Based on the findings from this study, ensuring privacy is a consistent goal of practice in most facilities. CMS does mandate that nursing homes provide a private space for residents to visit with loved ones (Centers for Medicare and Medicaid Services, 2017). Despite this, nursing homes may experience problems providing this service to residents due to lack of private space. This finding highlights a need for further emphasis on how facilities can uphold their commitment to ensuring privacy for residents, specifically when visiting with a spouse or partner.

### **Routine Activities**

In further exploration of the ways nursing homes preserve relationships, participants also pinpointed activities such as sharing a bingo card, enjoying a holiday party together, or gardening together as helpful activities in preserving relationships between residents and their spouses or partners. The emphasis placed on activities like crafts, bingo, and holiday celebrations is noteworthy considering these items were also identified by participants as ideal components of a relationship preserving program. In describing an ideal program, many participants stressed the importance of offering activities specifically for couples. The little things, such playing bingo together and other activities previously mentioned are commonly offered activities in an activity program, however, these activities become ideal components of a relationship preserving program when they are tailored towards couples rather than to all nursing home residents in general. However, most participants described activities that are normally a part of a facility's activities department, but with a couple-only emphasis, rather than proposing new activities to design for this purpose. For example, couples' bingo or couples' exercise activities. Specifically, there would be benefit in tailoring activities that both facility staff and residents are already familiar with to interventions that are specifically designed for couples. This highlights the need for possible changes or additions to current activity practices in the nursing home setting.

The emphasis that interview participants placed on the "little things" brings to the forefront a different or new way to look at programs or policies in this area. It brings to question the necessity of the establishment of written policies or formal programs for the purpose of relationship maintenance. Is there a need for such a formal policy or program or can these

relationships be maintained by simply incorporating small changes or additions throughout a facility's activity program? If yes to the latter, the findings from this study should prove encouraging for all nursing home facilities and their continued efforts to meet the psychosocial needs of their residents.

### **Need for Services**

Because most represented facilities provided both short-term rehabilitative services in addition to long-term skilled services, participants were asked to share their perspective on the need for attention to the couple relationships among both short-term and long-term stay residents. Participants perceived a greater need for relationship preserving services for long-term residents in comparison to short-term residents. Additionally, participants responded to questions related to resident participation in various activities. More participation by long-term residents than short-term residents was reported consistently across each activity area. The expression of a greater need for relationship maintenance services for long-term residents may be due to several factors. Perhaps this is based on the idea that short-term residents will reside in the facility for a shorter period of time and therefore there is little to no need for services to preserve relationships. It is also possible that short-term residents tend to be younger or healthier than their long-term counterparts, and therefore have the ability to manage activities to maintain their relationships. Additionally, the perceived need for services for short-term stay residents is little to none because services are already sufficient for this group and participation is steady.

However, due to the nature of their stay and commitment to participating in therapy services, the need for relationship maintenance services becomes difficult to track among short-term residents. This finding is noteworthy because of the effect that this perceived need for both resident groups may have on the delivery of services to maintain relationships throughout the facility. Although short-term residents reside in the facility for a shorter period of time than their long-term counterparts, a brief length of stay does not exclude these residents from experiencing threats to their romantic partner attachment system. Additionally, because of this, these residents may also experience a greater risk of depression, health problems, and unhealthy behavior practices (Das, 2013). Unfortunately, the less perceived need may result in a lack of equity in services not being offered to short-term and long-term residents. This is especially relevant considering that short-term residents may reside in a nursing home up to 100 days, not so ‘short-term’ (Harris-Kojetin et al., 2019).

### **Resident Feedback**

The use of each individual couples’ preference in the development of an ideal relationship maintaining program was a notable finding of the present study. This is certainly true as nursing homes strive to personalize each resident’s plan of care and to ensure that the psychosocial needs of each resident are being met and any concerns are addressed. However, nursing homes can also obtain information about residents’ needs and concerns through information resulting from resident council meetings. Resident councils are “organized, self-governing, decision-making groups of long-term care residents meeting regularly to voice their needs and concerns and to have input into the activities, policies, and issues affecting their lives

in the facility” (Eckles, 2005, p.3). These councils allow residents to maintain a sense of autonomy and self-determination in ‘their own home’. Resident council meetings could provide an additional opportunity for social workers, and others, to gain a better understanding of the concerns of residents as both a group and as individual residents. Council meetings also may provide an additional avenue for couples in this setting to share their concerns or to provide feedback on the facility’s effort to preserve their relationship with their spouse or partner. However, residents must regularly participate in resident council activities for social workers to obtain a thorough understanding residents’ concerns and needs. Therefore, it is essential for social workers and other facility personnel to not only ensure that residents are aware of the existence of this council, but to also encourage regular participation. Resident council meetings are an additional source of information for social workers in the development of relationship maintaining policies and programs and for feedback from the residents when new programs are implemented.

### **A Collaborative Approach**

Although social workers are often at the forefront of ensuring that the psychosocial needs of nursing home residents are met, both through facility services and making referrals, carrying out an ideal relationship maintenance program in this setting requires a collaborative approach including all departments within in facility. This is apparent given the range of activities highlighted in the present study as components of an ideal relationship maintaining program. It is essential to note the varying skills, techniques, and departmental resources that are needed to

carry out what these social workers considered an ideal program for couples in the nursing home setting. For example, while all facility personnel may be responsible for ensuring couples privacy, room arrangements may be the responsibility of a facility's admissions department. Similarly, while anniversary celebrations and carrying out activities specifically for couples may be the responsibility of a facility's activity department, facilitating couple outings may be the responsibility of facility administration or a collaborative approach between both departments. In addition, both a facility's admissions department and/or social service department might be charged with collecting couples' activity preferences.

This division of services and activities by departments further highlights a need for detailed programs to support a facility's written policy and for it to be well-coordinated. Social workers can take the lead/responsibility for coordinating these programs. It is clear that a collaborative approach is necessary to maintain a program that contains the ideal activities and services for couples in the nursing home setting.

### **Sample Program Outline**

A collaborative approach is necessary for a relationship maintenance program in this setting. A sample outline of a program in this setting is provided below. Although nursing homes are similar in consideration of the population served, these facilities often vary the ways in which they carry out day-to-day facility operations. Therefore, the provided sample only serves as a framework, allowing each facility to tailor the program's content based on the available resources.

The Spouse and Partner Relationship Preservation Program (SPRP) was developed to provide guidance for creating and implementing unique plans of care for residents who have a spouse or a partner. It is essential that efforts are made to preserve the spousal and partner relationships among our residents, as these relationships play a key role in the physical, mental, and overall psychosocial well-being of our residents. This program outline contains the following information:

- Resident Preference Form
- Facility Activity Program
- Additional Available Services

### ***Resident Preference Form***

The Resident Preference Form outlines all services offered in the SPRP program. It is the responsibility of the admission coordinator as well as the social services department to ensure that all newly admitted residents who have a spouse or a partner are made aware of the services that are outlined in the Resident Preference Form. Please adhere to the steps below to ensure proper implementation of the Spouse and Partner Relationship Preservation Program.

- Completed Resident Preference Form upon admission to ascertain if the resident is interested in participating in the SPRP program. In the event that both partners are admitted together, only one form should be completed with copies of the form included in both charts.
- The social worker will review the Resident Preference Form during each care plan meeting to assess for changes to preferences or changes to participation in the program.

Additionally, the social worker will ensure the activities department has an updated copy of each resident's preference form at all times.

### ***Facility Activity Program***

It is the responsibility of the facility's activity program to ensure that couple specific activities are available for residents and their spouses or partners. The activities department will be responsible for making residents aware of the date and times that SPRP activities will occur. In addition, these activities must be outlined on the activities calendar each month.

- The activities department must offer a minimum of two SPRP activities each week. An exception may be made at times when no SPRP participants are residing in the facility.

### ***Additional Available Services***

Additional services are also available if a resident requests services that are not offered by the facility's activity department. Additional services include martial counseling (community collaborator), outings, anniversary celebrations, private meals, and private movies.

- Outings -Requests for outings must be made 48 hours (four days for facility van use) in advance of the expected leave date. Residents or their spouses or partners may make this request with social services. When a request is made, the medical director must be notified of the details. The medical director will assess and address any concerns related to the outing and provide feedback to the social worker. Immediately upon approval from the medical director, social services must notify all of the members of the interdisciplinary team including front desk personnel, Director of Nursing, therapy services, and dietary. The Director of Nursing will notify the nursing department of the

outing no later than 24 hours prior to the outing. The clinical team will provide the resident with the necessary equipment and medication that will be needed during the outing.

- Marital Counseling - Marital counseling services are also available. This service must be requested by the resident of social services. Once a request is made, social services is responsible for contacting a marital counselor who is contracted with the facility to provide services. Social services is also responsible for scheduling a date and time that is agreed on by both the couple and the therapist.
- Anniversary Celebrations - Anniversary celebrations require a 24-hour notice to social services. Upon receipt of the request, social services will notify dietary services if food and beverages are to be provided by the facility. If the resident, or resident's family, provides food and beverages, social services will ensure availability of the facility's social room for the date and time of the event.
- Private Meals and Movies - Requests for Private Meals and/or Movies must be made at least 48 hours in advance. This request must be made to social services. Upon receipt of the request, social services will notify dietary services if food and beverages are to be provided by the facility. If the resident, or resident's family, provides food and beverages, social services will ensure availability of the facility's social room for the date and time of the event.

### **Coronavirus Pandemic**

In March of 2020, the spread of the coronavirus resulted in community ‘shutdowns,’ restrictions to everyday life, and have created an overall ‘new normal’ for everyone. This statement is perhaps nowhere more true than for the nursing home industry, as CMS mandated visitation restrictions, screening requirements, and operation changes in nursing homes across the country. These restrictions resulted in limitations to resident-to-resident interaction and no interaction between residents and their loved ones from the community. Both quantitative and qualitative data paint a clear picture of the impact that these restrictions have had on residents’ relationships as well as their mental health. The social workers in this study noted the adverse effect that the loss of interactions with loved ones had on a residents’ mental and physical health. Participants shared their observations of changes such as increases in the prescribing of antidepressants, exacerbation of dementia symptoms, and increases in deaths unrelated to coronavirus among nursing home residents. Further, the influence that changes to these close interactions have on the physical and mental health of residents is supported by attachment theory. Attachment theory suggests that disruption of a close relationship or attachment can threaten an individual’s mental health and ultimately their physical health as well. An increase in feelings of loneliness, anxiety, and depressive symptoms have all been highlighted in recent literature exploring the impact of coronavirus on older adults’ mental health (Brennan et al., 2020; Galea et al., 2020).

Although the end of the COVID-19 pandemic is yet unknown, additional research in this area, both during and after the pandemic, may highlight ways in which close relationships

influence the overall well-being of nursing home residents and how these relationships can be maintained under extraordinary circumstances.

### **Implications for Social Work Practice**

The present study has several implications for social work practice. In the nursing home setting, social workers have a primary responsibility to address the psychosocial needs of each individual resident, as is observed in the current data. The findings from this study do not necessarily identify an overwhelming need for services to preserve spouse and partner relationships according to these nursing home social workers. However, the data does have implications for nursing social workers to consider as they address the psychosocial needs of their residents. From an advocacy perspective, these findings have implications for social work practice as social workers are often one of the primary advocates for nursing home residents. From an individual approach, social workers can not only ensure that residents are aware of services for couples upon admission but can also encourage participation throughout the residents' stay in the facility. Additionally, social workers can use these findings to advocate for changes to their facility's current written policies to ensure that each resident and staff member has a clear understanding of what services are offered and how these services are carried out. Changes in programs and increased conversation in this area will pave the way for policy development in the long-term care industry as social workers share their own experiences and practice techniques to preserve these relationships. Results may further provide direction for practitioners when providing individual counseling, care planning services, and policy development collaboration.

A notable finding of the present study is the identification of privacy as an important component of preserving relationships in the nursing home setting. Similarly notable is the lack of private areas in nursing homes that are designated for spousal or partner interactions. These findings warrant further exploration into creative ways for facilities to maintain private space for spousal/partner interactions, per requirement by CMS. Social workers can use the information from the present study to initiate conversations about the importance of spousal and partner privacy within their facility and to design supportive services to ameliorate spousal/partner relationships.

Therefore, an ideal program for this purpose would utilize activities that are offered to all nursing home residents, while reserving specific days of the week or times throughout the day to offer activities for couples only. While outings and date nights are common activities for couples to participate in, it is important to consider the physical and mental limitations that are often experienced by nursing home residents. Therefore, an ideal intervention program must include services under two different umbrellas, “in-house services” and “community services.” With these two areas in mind, facilities will be able outline what services are offered under each area, share this information with couples upon admission, and, in collaboration with the facility’s interdisciplinary team, allow each couple to select which area works best for them.

While a program such as the one previously discussed is essential in the nursing home setting, additional education for nursing home social workers is warranted. This is especially important in considering statistical data on the educational levels for nursing home social workers. Approximately 62% of social service directors possess a BSW while, only 35% possess

an MSW. The remaining 3% of nursing home social service workers do not possess a social work degree (Social Work Policy Institute, 2010). While BSW social workers are equipped with the tools that are needed to provide general social work services such as case management and discharge planning, this group has not received specialized training in clinically-based social work interventions. Therefore, additional education is recommended to assist social workers with understanding current research evidence-informed practices among older adults; recognizing and resolving spousal and partner problems; and designing creative programs that will correlate with the residents' and facilities' priorities. Additional education may take place in many forms. Per CMS guidelines, nursing home facilities are required to provide continuing education opportunities to their staff through the use of in-service training (Centers for Medicare and Medicaid Services, 2014). Although CMS requires facilities to provide training on abuse and neglect and caring for individuals with dementia, in-service training may also be helpful for social workers and other facility staff in further understanding the unique needs and current intervention techniques for this population. Additionally, in-facility continuing education opportunities may also be made available through the social work board examiners program in each respective state. For example, a facility may invite a marital counselor who specializes in working with older adult couples to speak to facility social workers while also offering an opportunity to acquire CEU's. However, to do this the facility must not only have sufficient financial resources for such a task, but the facility must also have a relationship with an organization that has the ability to grant CEU's, such as NASW or a university school of social work. Additionally, training that focuses on techniques to preserve relationships among residents

is beneficial for not only social workers, but other facility personnel as well. This training may be best facilitated by the social worker and offered to all facility personnel. Also, social workers may also take advantage of the various online and in-person training opportunities offered by both small and large organizations within their local community to hone their skills and increase their knowledge of issues that older adult couples commonly face. However, to maximize training opportunities and participation, social workers must first advocate for themselves to facility administration on the importance of providing financial support for continuing education opportunities outside of the facility.

This study revealed social work practice concerns relevant to the COVID-19 pandemic restrictions. Interview participants consistently reported the negative affect of residents' inability to visit with their loved ones. Although further research must be done in this area to obtain a full picture of the impact of the coronavirus among this population, social workers may use the present data as motivation to ensure that personal connections are preserved and maintained. Only by doing this, will practitioners fully address their residents' psychosocial needs.

### **Study Strengths and Limitations**

The present study has both strengths and limitations. One of the strengths of the study is that it addresses a gap in literature. Although previous studies have explored staff attitudes regarding intimacy, as well as what intimacy "looks like" in the nursing home setting, no literature was found that explores what services/interventions are provided by facilities to assist residents and their spouses or partners to maintain relationships. An additional strength of this

study is the use of both quantitative and qualitative methods of data collection. The use of mixed methods to explore couple relationships allowed for a deeper exploration of services in this setting.

A primary limitation is that the survey sample was small and therefore the results of the survey are not nationally representative. However, it may be representative of how services are provided to maintain spousal and partner relationships in nursing homes in the four represented states. Another limitation is that since facilities in Georgia, Mississippi, and Tennessee with less than 120 beds were not included in the final sample, the proposed study was not able to capture service delivery to the population of interest in the smaller facilities in these three states.

The study utilizes a self-administered survey and both the researcher and the respondents are social workers. Therefore, due to social desirability, respondents may unconsciously provide inaccurate responses to present themselves well to the researcher or show their facility in a good 'light,' and with self-report there is a possibility for inaccurate or untruthful responses in general (Rubin & Babbie, 2017). However, assurance of confidentiality and anonymity and the respondents' interest in the topic may mitigate this effect. In addition, while triangulation was used during the data collection process this technique was not used during the data analysis process as one coder was used to analyze and interpret qualitative data. Last, because this study took place during the coronavirus pandemic, responses related to current facility practice might have been influenced by the coronavirus restrictions enforced by many nursing home facilities at the time. However, both survey respondents and interview participants were prompted to provide responses based on their "pre-COVID" practices when relevant.

## **Future Research**

The present study provides a foundation for understanding the services available for couples in nursing homes. Additional studies in this area may be beneficial to understand the issue of privacy in nursing homes and to focus on gaining a better understanding of what makes spousal and partner privacy difficult to facilitate. A study of this nature may involve both social workers and residents as participants to obtain both perspectives regarding increasing opportunities for privacy. Further exploration of how general nursing home activities can be tailored into couple-specific activities is also necessary. This exploration might take place through the administration of a survey that focuses on gaining a clearer picture of the different parts of activity programs in this setting. For the most accurate responses, this survey might be distributed to activity personnel and/or facility social workers. Also, in qualitative studies data may be collected through interviews with activity personnel or focus groups with nursing home residents who have a spouse or a partner. Additionally, further exploration must also take place through practitioner evaluation of new programs and services with the purpose of establishing guidelines and designs for integrating a couple specific program into an already existing activities program.

In any type of future research in this area, the residents and spouses are an integral part of the investigation. Further examination of the experiences of nursing home residents who have a spouse or partner might not only add important knowledge to the literature in this area but may also influence social work practice and policy development in this setting. This type of exploration provides an opportunity for nursing home facilities to obtain feedback from the

individuals to whom they are providing services. The integration of feedback from nursing home residents who have a spouse or a partner will highlight what current practices in their facilities work and what practices are not so helpful. This also gives residents and their spouses or partners an opportunity to offer suggestions on how current facility activities or practices might be improved to meet the relationship needs of residents and their spouse or partner.

In addition, future research should focus on the impact of the coronavirus pandemic, specifically a study that focuses on the pandemic restrictions and its effects on the mental and physical well-being of nursing home residents. This study might also emphasize the importance of spousal and partner relationships by comparing residents' physical and mental health both during and after the pandemic.

### **Conclusions**

This study illuminated the programs and practices that nursing homes are already using to ensure that their residents have the resources to preserve significant relationships with their spouse or partner. Based on the findings, nursing home social workers are aware of the need to preserve these relationships, however, their facility may not possess the tools/resources to provide all or most of the services that might be included in an ideal relationship preserving program. Therefore, while this study contributes to the conversation, more is needed. Additional research in this area, as well as the implementation of programs on the facility level, will further provide direction for the best practices to ensure preservation of these essential spousal/partner relationship.

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APPENDIX A: Research Questions and Corresponding Survey Items

| Research Questions   | Survey Items   |
|--|--|
| <p>Question 1:</p> <p>1) How do nursing home facilities preserve spousal/partner relationships of residents?</p> <p>A. What interventions, programs, and activities are available to maintain spousal/partner relationships among residents?</p> | <ol style="list-style-type: none"> <li>1) Does your facility have a written policy that addresses the delivery of services that focus on the preservation of spousal or partner relationships?</li> <li>2) If yes, what barriers are experienced in implementing this policy that focuses on preserving spousal or partner relationships?</li> <li>3) What type of accommodations or services are included in your facility's written policy?</li> <li>4) Does your facility have a program designed specifically for residents who have a spouse or partner?</li> <li>5) What role you have in designing services and programs specifically for residents who have a spouse or partner?</li> <li>6) If services exist specifically for residents who have a spouse or partner, what role do you play in implementing these services? Please describe.</li> <li>7) Within your facility's organized activities program, what type of activities might serve to preserve spousal or partner relationships between residents and their spouse or partner?</li> <li>8) Other than designed programs or organized activities, what additional activities or interventions might serve to target spousal or partner relationships?</li> </ol> |

|   |   |
|---|---|
|   | <p>9) Of all the services/activities in which residents participate with their spouses or partners, which do you think are most effective in maintaining relationships?</p> <p>10) How many residents in your facility have a spouse or partner who resides in your facility as well?</p> <p>11) How many resident in your facility share a room with their spouse or partner?</p> <p>12) How many residents in your facility have spouses or partners who reside in the community?</p>   |
| <p>Question 2:<br/> How do nursing home social workers and other staff facilitate the maintenance of relationships among residents and their spouses/partners?</p> <p>A. What specific roles do social workers have in the design and implementation of available services?</p> <p>B. What roles do other nursing home staff have in design and implementation of available services?</p> | <p>13) When a resident is admitted, how do you become aware that he or she has a spouse or partner?</p> <p>14) When a resident as admitted, how do other members of the care team become aware of the presence of a spouse or partner?</p> <p>15) How frequently do you discuss the preservation of spousal or partner relationships with residents who have a spouse or partner?</p> <p>16) During you work day, how often do you communicate with other team members about residents' psychosocial needs?</p> <p>17) During your work day, how often do you speak with residents about their psychosocial needs?</p> <p>18) How much are you involved in providing the following activities:</p> <ul style="list-style-type: none"> <li>a. Providing individual counseling</li> <li>b. Providing group counseling</li> <li>c. Providing caregiver support activities</li> </ul> |

|  |   |
|--|---|
|  | <ul style="list-style-type: none"><li>d. Providing family counseling</li><li>e. Problem solving with families</li><li>f. Help coordinate planned resident activities</li></ul> <p>19) What type of activities are included in your facility's organized activity program?</p> <p>20) What type of activities offered in your facility would you identify that serve to preserve spousal or partner relationships among residents?</p> |
|--|---|

APPENDIX B: Phone call Script/Guide to Determine Licensure of Social Work  
(Facilities with less than 120 beds)

*Hi, will you transfer me to social services please?*

*Hi my name is Shanae Shaw and I am a doctoral student in the School of Social Work at the University of Alabama. I am conducting a research study in which my target respondents include full-time licensed nursing home social workers. Do you have a licensed social worker on staff in your facility?*

If response is yes,

*As previously mentioned, I am conducting a research study involving a survey of nursing home licensed full-time social workers and I am hopeful that you will participate. Can I please have your name and email address?*

APPENDIX C: Phone Call Script/Guide for Potential Participants' Contact Information  
(Facilities with more than 120 beds)

*Hi, will you transfer me to your social services director?*

*Hi my name is Shanae Shaw and I am a doctoral student in the School of Social Work at the University of Alabama. I am conducting a research study involving a survey of nursing home licensed full-time social worker and I am hopeful that you will participate. May I please have your name and email address for your participation? Thank you very much.*

## APPENDIX D: Email Invitation to Participate

Dear [Participant Name],

Hello, my name is Shanae Shaw and I am a doctoral student at the University of Alabama. I invite you to participate in a dissertation research study about nursing home facility services and programs offered to preserving residents' spousal and partner relationships.

This study explores how nursing home facilities provide specialized services for residents who have a spousal or partner relationship. The survey includes general questions on services and activities in the nursing home setting but focuses specifically on services available for nursing home residents to assist in maintaining spouse and partner relationships and/or partnerships. I am interested in gaining a better understanding of how these relationship attachments of between residents and their spouses or partners are maintained. This study will focus not only on your role in the process of service delivery for these residents and their spouses and partners, but it will also draw upon your professional perspectives regarding policies that are currently in place and processes that all staff follow regarding relationship maintenance services in your facility. Your input will help identify the strengths and limitations in service delivery for residents who have a spouse or partner.

The survey is being conducted through the online survey administrator "Qualtrics". Through this method of administration, your responses are de-identified and therefore anonymous. Your name/email will not be linked with your responses and I will only receive that data collected in de-identified form directly from the survey administrator. Your name and email address, while known to me, are only to be used to initially contact you and will be kept confidential in a password-protected computer file.

If you prefer not to be contacted again, please response to this message asking me to remove your email address from any future mailings.

Since responses to Qualtrics surveys are anonymous, there will be no way to know whether or not you have responded to the survey. If you do not return the opt-out message, you will be contacted again with this request in 2 weeks inviting you to participate in the study. One final invitation will be sent two weeks after that for one last opportunity to participate. In total, the survey link will be active for 4 weeks.

Please follow the link below. It will take you directly to the survey. I ask that you review the consent document and proceed with the survey after you provide consent to participate. Your participation is completely voluntary.

After you review this email, I hope that you decide to participate. The survey will take about 30-35 minutes to complete. Please complete it within the next 2 weeks if possible.

If you have questions about any aspect of the study, you may contact me or my faculty advisor, Dr. Ellen Csikai, at:

Shanae Shaw, LGSW  
Ph.D. Candidate  
School of Social Work  
The University of Alabama  
205-492-8269  
[sklogan@crimson.ua.edu](mailto:sklogan@crimson.ua.edu)

OR

Ellen L. Csikai, Ph.D., MSW, MPH  
Professor of Social Work  
School of Social Work  
University of Alabama  
205-348-4447  
[ecsikai@sw.ua.edu](mailto:ecsikai@sw.ua.edu)

If you have questions about your rights as a research participant, or concerns or complaints about the research, you may contact Ms. Carpantanto Myles, The University of Alabama (Tuscaloosa, Alabama, United States), Research Compliance Officer, at 205-348-8461 (or email at [cmyle@fa.ua.edu](mailto:cmyle@fa.ua.edu)).

Thank you again for your time and consideration of this request.

## APPENDIX E: Email Invitation to Participate in Interview

Good Morning (Mr. or Ms.),

I hope this email finds you well. First, I would like to thank you for participating in the Nursing Home Social Work Survey. Your participation is truly appreciated. Second, I would like to thank you for offering time out of your schedule to take part in the interview portion of the survey.

I plan to conduct interviews between (available dates for interviews)

Please let me know which date and time/ timeframe would be best for you. My goal is to interview you on a date and time that fits well into your schedule.

I have attached the consent form for participation in the interview to this email for your review and signature. The interview will be recorded, however, as a participant, you will be able to decide if you would like the interview to take place via phone or video conference (video conference interviews will take place via Zoom). Interviews will be recorded for transcription purposes only. All audio and video recordings and transcriptions will be kept in a secure online folder. When the study is completed and the data have been analyzed, your personal information, in addition to audio and/or video recordings and transcriptions will be destroyed. Your name will not be used in any report.

Lastly, as an interview participant, you will receive a \$10 Amazon gift card for your participation, which will be sent to you electronically, unless you prefer an alternate method of delivery.

If you are still interested in participating in the interview portion of this study, please respond to this email with the following information:

- Completed consent form
- Date and time for the interview
- Method of Interview (telephone or video)

If you are no longer interested in participating in the interview portion of this study, please simply respond to this email stating that you are no longer interested in participating.

I am looking forward to hearing from you soon. Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,

Shanae Shaw

## APPENDIX F: Consent to Participate in Study

Title of Research: The preservation of spousal and partner relationships among nursing home residents: a preliminary study of service delivery and availability

Investigator: Shanae Shaw, LGSW, Principal Investigator Ph.D. Candidate, University of Alabama School of Social Work

Ellen L. Csikai, Ph.D., M.S.W., M.P.H., Faculty Advisor, Professor, University of Alabama School of Social Work

### Purpose/Description

This is a research study. The purpose of the study is to learn how nursing home facilities are providing services that promote the maintenance of spouse or partner relationships and/or partnerships among nursing home residents.

### Procedure

Participation in this study involves completing a survey. This survey contains questions about how nursing home facilities provide services for residents who have a spouse or partner. Survey questions also focus on policies and procedures utilized by nursing home facilities in guiding service delivery for this group.

I am interested in the availability of services for residents in nursing homes facilities, with an emphasis on services and activities that aim to promote and maintain spousal and partner relationships among residents.

The survey should take about 30-35 minutes.

### Criteria for Subject Selection

Licensed full-time nursing home social workers who work in CMS-certified nursing home facilities in the states of Alabama, Georgia and Mississippi are being invited to participate.

### Risks/Benefits

No risks are anticipated to the participants of this study. Identification of current practices for the population of interest may lead to future development of guidelines that will lead to specialized care for this group in the nursing home setting.

### Confidentiality

Your name and email address used to contact you will be kept confidential and only by the researchers in a password-protected computer file. All information, including identity of the nursing home facilities in the sample, will be kept confidential. When reporting the results, only aggregate data will be used, no information about individuals or specific nursing home facilities will be reported.

### Right to Withdraw

Your participation in this study is completely voluntary. You have the right to participate and to withdraw at any time from participation even after the study has begun. You may contact the researcher directly with your request to withdraw.

### Cost/Compensation

You will not receive any payment for participating in this study. There will be no cost to you for participation.

### Study-related contact Information

For questions related to any aspect of the study, you may contact Shanae Shaw, LGSW at 205-492-8269 or [sklogan@crimson.ua.edu](mailto:sklogan@crimson.ua.edu) or Ellen L. Csikai, PhD at 205-348-4447 or [ecsikai@sw.ua.edu](mailto:ecsikai@sw.ua.edu) (both are principal investigators for this study).

Furthermore, if you have questions about your rights as a research participant, or concerns, or complaints about the research, you may contact Ms. Carpentanto Myles, The University of Alabama (Tuscaloosa, Alabama, United States), Research Compliance Officer, at 205-348-8461 (or email at [cmyles@fa.ua.edu](mailto:cmyles@fa.ua.edu)).

Before beginning the survey, please complete the following:

Please check:

\_\_\_\_\_ AL PARTICIPANTS - I am an adult (over age 19 -age of consent in Alabama)

\_\_\_\_\_ GA PARTICIPANTS- I am an adult (over age 18- age of consent in Georgia)

\_\_\_\_\_ MS PARTICIPANTS- I am an adult (over age 18- age of consent in Mississippi)

\_\_\_\_\_ I consent to participate in this study

Thank you for your participation in this study

## APPENDIX G: Consent to Participate in Study Interview

Title of Research: The preservation of spousal and partner relationships among nursing home residents: a preliminary study of service delivery and availability

Investigator: Shanae Shaw, LGSW, Principal Investigator Ph.D. Candidate, University of Alabama School of Social Work

Ellen L. Csikai, Ph.D., M.S.W., M.P.H., Faculty Advisor, Professor, University of Alabama School of Social Work

### Purpose/Description

This is a research study. The purpose of the study is to learn how nursing home facilities are providing services that promote the maintenance of spouse or partner relationships and/or partnerships among nursing home residents.

### Procedure

Participation in this study involves completing a telephone or video interview with the researcher. The interview will focus on questions related to how nursing home facilities provide services for residents who have a spouse or partner. Questions also focus on policies and procedures utilized by nursing home facilities in guiding service delivery for this group.

I am interested in the availability of services for residents in nursing homes facilities, with an emphasis on services and activities that aim to promote and maintain spousal and partner relationships among residents.

The interview should take about 45-60 minutes.

### Criteria for Subject Selection

Licensed full-time nursing home social workers who work in CMS-certified nursing home facilities in the states of Alabama, Georgia and Mississippi who have volunteered to participate in a telephone interview following the completion of the online survey portion of the study are being invited to participate.

### Risks/Benefits

No risks are anticipated to the participants of this study. Identification of current practices for the population of interest may lead to future development of guidelines that will lead to specialized care for this group in the nursing home setting.



Participant Name: \_\_\_\_\_

Date: \_\_\_\_\_

Participant Signature: \_\_\_\_\_

## APPENDIX H: Survey of Nursing Home Social Workers

The purpose of this survey is to explore how your facility addresses the preservation of spousal and partners relationships among residents in your facility. The survey is divided into four sections: (1) Facility Policies and Services Provided to Preserve Resident Spousal and Partner Relationships, (2) COVID-19 Pandemic Services and Facility Restrictions, (3) Facility Routine Practices and Demographics, and (4) Background Information.

### **Facility Policies and Services Provided to Preserve Resident Spousal and Partner Relationships**

The following section contains questions about your facility's policies and programs related to residents with spouses or partners. Please answer the following questions based on your facility's "pre-COVID" policies, programs, and services.

The 'preservation of spousal and partner relationships' refers to the maintenance of the intimate partnership attachment between residents and their spouse or partner and does not refer only to sexual intimacy.

- 1) In which state is your facility located?

Alabama  
Georgia  
Mississippi

For the next three questions please provide response for both short-term stay and long-term stay residents.

- 2) Currently, how many residents in your facility have spouses or partners who resides in your facility as well?

Enter Number

- 3) Currently, how many residents in your facility share a room with their spouse or partner?

Enter Number

- 4) Currently, how many residents in your facility have spouses or partners who reside in the community?

Enter Number

5) Does your facility have a **written policy** that addresses the delivery of services that focus on the preservation of spousal or partner relationships?

- Yes
- No
- Don't know

6) What barriers are experienced in implementing this **written policy** that focuses on preserving spousal or partner relationship? (Check all that apply)

- Lack of private space for resident and spouse to visit
- Availability of staff needed to implement policy
- Attitudes of facility administration
- Attitudes of facility staff
- Other (please specify)
- N/A

7) What type of accommodations or activities are included in your facility's **written policy**? (Check all that apply)

- Private space accommodations for resident and spouse to visit
- Private meals or dinner accommodations
- Couple activities
- Couple outings
- Other (please specify)
- No special accommodations
- N/A

8) Does your facility have a **program** designed specifically for residents who have a spouse or partner? (whether based on written policy or not)

- Yes
- No
- Don't know

9) If yes, how often do **short-term stay** residents and their spouses or partners participate in your facility's program? Please rate the frequency of participation from 0-10 with "0" not at all to '10' always.

|                   | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|-------------------|---|---|---|---|---|---|---|---|---|---|----|
| Please select the |   |   |   |   |   |   |   |   |   |   |    |

|             |  |  |  |  |  |  |  |  |  |  |  |
|-------------|--|--|--|--|--|--|--|--|--|--|--|
| best answer |  |  |  |  |  |  |  |  |  |  |  |
|-------------|--|--|--|--|--|--|--|--|--|--|--|

10) If yes, how often do **long-term stay** residents and their spouses or partners participate in your facility’s program? Please rate the frequency of participation from 0-10 with “0” not at all and “10” always.

|                               | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|-------------------------------|---|---|---|---|---|---|---|---|---|---|----|
| Please select the best answer |   |   |   |   |   |   |   |   |   |   |    |

11) If yes, please describe the major aspects of your program? (Check all that apply)

- Private time (either inside or outside of residents’ room) between resident and their spouse or partner
- Private meals for residents and their spouse or partner
- Counseling or therapy services for the preservations of spousal and partner relationships
- Couple outings
- Activities specifically for residents who have a spouse or partner
- Other, please specify

12) What role do you have in designing services and programs specifically for residents who have a spouse or partners?

- Solely responsible for designing services and programs
- Collaborate with members of the interdisciplinary team to design services and programs
- Social worker is not involved in the designing of services or programs
- Other (please specify)
- N/A My facility does not have this type of policy or program

13) If services exist specifically for residents who have a spouse or partner, what role do you have in implementing these services?

- Solely responsible for implementing services and programs
- Collaborate with members of the interdisciplinary team to implement services and programs
- Social worker is not involved in the implementing of services or programs
- Other (please specify)
- N/A My facility does not have this type of policy or program

14) Which of the following activities are **short-term stay** residents likely to participate in?  
(Select the top 5 activities from the list below)

- Board and Card Games
- Birthday Parties
- Ice cream socials
- Musical events
- Holiday Parties
- Exercising
- Pet Therapy
- Gardening
- Crafts
- Field Trips
- Other (please specify)

15) Which of the following activities are **long-term stay** residents likely to participate in?  
(Select the top 5 activities from the list below)

- Board and Card Games
- Birthday Parties
- Ice cream socials
- Musical events
- Holiday Parties
- Exercising
- Pet Therapy
- Gardening
- Crafts
- Field Trips
- Other (please specify)

16) Within your facility's organized activities program, what type of activities might serve to preserve spousal or partners relationships between residents and their spouse or partner?

(Please list and describe)

17) Other than designed programs or organized activities, what additional activities or interventions might serve to target spousal or partner relationships?

(Please list and describe)

18) Of all the services/activities in which residents participate with their spouses or partners, which do you think are most effective in maintaining relationships?

(Please list and describe)

19) How important do you think it is to specifically focus on the preservation of residents' spousal and partner relationships among **short-term stay residents**? Please rate your response from 0-10 with "0" meaning there is no need (not important) and "10" meaning there is a high need (utmost importance).

|                               | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|-------------------------------|---|---|---|---|---|---|---|---|---|---|----|
| Please select the best answer |   |   |   |   |   |   |   |   |   |   |    |

20) How important do you think it is to specifically focus on the preservation of residents' spousal and partner relationships among **long-term stay residents**? Please rate your response from 0-10 with "0" meaning there is no need (not important) and "10" meaning there is a high need (utmost importance).

|                               | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|-------------------------------|---|---|---|---|---|---|---|---|---|---|----|
| Please select the best answer |   |   |   |   |   |   |   |   |   |   |    |

21) How frequently do you discuss the preservation of spousal or partner relationships with residents who have a spouse or partner? Please rate your response from 0-10 with one being not at all to and 10 extremely frequent.

|                               | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|-------------------------------|---|---|---|---|---|---|---|---|---|---|----|
| Please select the best answer |   |   |   |   |   |   |   |   |   |   |    |

For the following questions please rate your response from 0-10 with one being not at all to and 10 extremely frequent.

22) During your work day, how often do you communicate with other team members about residents' psychosocial needs?

23)

|                   | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|-------------------|---|---|---|---|---|---|---|---|---|---|----|
| Please select the |   |   |   |   |   |   |   |   |   |   |    |

|             |  |  |  |  |  |  |  |  |  |  |  |
|-------------|--|--|--|--|--|--|--|--|--|--|--|
| best answer |  |  |  |  |  |  |  |  |  |  |  |
|-------------|--|--|--|--|--|--|--|--|--|--|--|

24) During your work day, how often do you speak with residents about their psychosocial needs?

|                               | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|-------------------------------|---|---|---|---|---|---|---|---|---|---|----|
| Please select the best answer |   |   |   |   |   |   |   |   |   |   |    |

25) What additional types of programs or interventions would you like to see offered in your facility to preserve spousal and partner relationships among residents, if any?

- Private time (either inside or outside of residents' room) between resident and their spouse or partner
- Private meals for residents and their spouse or partner
- Counseling or therapy services for the preservation of spousal and partner relationships
- Couple outings
- Activities specifically for residents who have a spouse or partner
- Other, please specify

26) Please add any other comments you have about spousal and partner relationships in the nursing home.

**COVID-19 Pandemic Services and Facility Restrictions**

This section contains questions about your facility's policies and practices during the COVID-19 pandemic.

27) What restrictions for visitation within the facility itself or with outside visitors were put in place?

- All residents' visitors not allowed in the building
- No outside agency personnel allowed, such as hospice
- Suspended residents' activities program
- None
- Other, please specify

28) Did/Has your facility made any exceptions for residents' spouses who live in the community regarding visitation?

Yes

No

I don't know

If yes, please describe.

29) How did staff encourage social 'connection' of residents with their spouses, families and friends who were not allowed in the building?

Organized phone calls between residents and their friends and family members

Organized and facilitated video chats between residents' friends and family members

Ensured presence of resident in care plan meetings with family members

Allowed residents to visit with friends and family members through a glass door or window

Other, please specify

30) Were any exceptions made to facilitate in-person visitation of residents and their spouses?

Yes

No

I don't know

If yes, please describe.

31) If yes, for what reasons were exceptions made?

32) What visitation was allowed for spouses and other family for residents who were actively dying?

Please describe

33) What restrictions were put in place for residents who have a spouse or partner residing in the facility?

No restrictions - spouses or partners were allowed to visit with one another as usual

Couples allowed to visit for only a specified time (for example 15-20 minutes per day)

Close monitoring of residents' spousal visits by nursing home staff

Spouses or partners were not allowed to visit with one another

Other, please specify

34) What was your role in development of the new policies to address the pandemic situation?  
(could list items here)

Solely responsible for the development of written policies

Worked in conjunction with interdisciplinary team members to develop written policies

Worked in conjunction with Administration to develop written policies

Not at all involved  
Other, please specify

35) Which new restrictions/policies put into place during the pandemic do you think will be long-lasting? (Check all that apply)

Staff requirement to wear personal protective equipment such as masks or gowns  
Visitation restrictions  
Fever screenings for everyone upon entering facility  
Quarantine unit for new admissions  
Social distancing during resident activities  
Other, please specify

36) In what ways did your daily work change during the height of the pandemic crisis in your facility? (Please select all that apply)

Focused on resident connections with family members  
Increased efforts to obtain advance directives for residents  
Conducted discharge planning for residents returning to the community  
More time spent providing emotional support to co-workers  
Assisted with disinfecting procedures  
Assisted with staff screening upon entry into the facility  
Assisted with decision making regarding admission referrals  
Conducted in-room activities for residents  
Other, please specify

37) Do you have any other comments regarding facility policies and restrictions during the COVID-19 pandemic?

### **Facility Routine Practices and Demographics**

The following questions help to describe your nursing home facility. Questions in this section will help to know about routine practices in your facility in addition to basic demographic information.

38) How is your facility currently classified according to the Centers for Medicare and Medicaid Services (CMS)

Medicaid and Medicare certified  
Medicaid only certified  
Medicare only certified

39) How many total beds does your facility have?

Enter number

40) What is the average number of residents in your facility on any given day (daily census)?

Enter number

41) What percentage of your residents at this time are residing in your facility on a short-term basis?

Enter number

42) How many residents at this time are residing in your facility on a long-term basis?

Enter number

43) In which type of community is your facility located?

- Large Metropolitan
- Small metropolitan
- Rural or Small town
- Suburban area
- Other, (please specify)

44) How many full-time social workers are employed at your facility

Enter number

45) How many part-time social workers are employed at your facility?

Enter number

### **Background Information: Professional and Personal**

The questions in this section are about your professional and personal background.

46) Which one of the following best describes your primary job title? (Select One)

Enter response

47) How many years have you been in social work practice overall?

Enter number

48) How many years have you been in social work practice in the nursing home setting?

Enter number

49) How long have you been working in your current facility?

Enter number

50) Your highest level of education is...

Bachelor's degree  
Master's degree  
PhD/DSW  
Other, please specify

The following three questions asks about your licensure status. Please provide a response only for questions related to the state in which you practice.

51) In your state of residency, what type of social work license do you hold? (Ex. LMSW)

52) With which race do you identify?

African American, non-Hispanic  
Asian  
African American, Hispanic  
Caucasian, non-Hispanic  
Mixed Race  
White, Hispanic  
Other, please specify

53) What is your age

Enter number

54) What is your gender

Male  
Female  
Other (please specify)

55) If you are willing to participate further in this study by completing a 45-60 minute interview via telephone, please provide your contact information below. If you are selected for an interview, you will receive a \$10 amazon gift card for your time.

Your name:

Your email address:

Agency/organization name:

Address:

Phone number:

THANK YOU FOR YOUR PARTICIPATION

## APPENDIX I: Semi-structured Interview for Social Workers

- 1) Tell me about what you do in your job in your facility. Do you have an “official” title? Does the title really describe what you do? Is there an “unofficial” title that would describe it better? In what ways?
- 2) As social workers, we know that relationships really matter, and relationships between partners, whether legally wives or husbands, hold importance for people, including residents living in your facility. What kinds of policies does your facility have on record that talk about services that focus on preservation of those relationships for your residents?

*(If your facility does not have such policy, program, or services do you see need for this type of written policy? Why or why not?)*

- 3) What gets in the way of the implementation of your facility’s written policy or the delivery of programs, or services concerning the preservation of spousal or partner relationships of the facility’s residents?

*(If your facility does not have a written policy, programs, or services what barriers might you anticipate if such policy existed in your facility?)*

- 4) *(If there is a program)* Describe the accommodations or services that are provided in your facility’s written policy or program? What are they? How many residents take advantage of them? Do residents and their partners know about the accommodations or services? What about the accommodations or services might make it hard for them to take advantage of the accommodations or services? How would you change the accommodations or services?

*(If your facility does not have a written policy or program, what type of services might be helpful in your facility to preserve relationships between residents and their spouse or partner?)*

- 5) Likely your Activities Department is offering activities that support relationship preservation/strengthening between residents and their spouses or partners even if they are not specifically intended for that purpose. Which of those activities do you think work to help maintain or strengthen those relationships? How or why do you think they work? What about the activities makes them suitable for that purpose, even if they weren’t intended to serve that purpose?

- 6) *(If there are services)* In your opinion is there a need for additional services or programs that emphasize the preservation of spousal or partner relationships? Why or why not?
- 7) What else could help? In an ideal world, what do you believe would be the best programs and what ways would be best to deliver them?  
*(Do you think such additional services would be feasible in your facility? Why or why not?)*
- 8) How have the policies put in place regarding the COVID-19 pandemic affected residents' relationships with their spouses or partners? (Which policies/practices were least helpful, or even detrimental? Which practices helped to mitigate negative effects?)
- 9) Tell me more about your thoughts about this topic of preservation of spousal and partners relationships among residents in your facility? What have I missed? What do you want to emphasize?

## APPENDIX J: Summary of Major Findings Emailed to Participants

### **The Preservation of Spousal and Partner Relationships Among Nursing Home Residents**

#### **Summary of Major Results**

I want to take this opportunity to thank you for your participation in my research study and share with you a summary of the major findings from the survey and individual interviews with social workers. I hope you will find them interesting, as I did.

#### **Survey Results**

##### **Facility Programs and Practices**

About 49% of respondents reported having a written policy to preserve relationships between residents and spouses/partners, however, only 22% reported having a specific program to carry out the facility's written policy. Several barriers to carrying out facility policies and programs were identified by respondents including lack of private space (34%), availability of staff to implement policies and programs (14%), and attitudes of facility staff (14%). Thirty-eight percent of respondents reported not experiencing barriers when implementing these policies or programs.

Additionally, respondents who reported having a relationship-enhancing program in their facility shared the program's major components. The most frequently reported component was facilitating private time for couples (54%). Facilitating private meals for couples was also reported frequently (25%). Additional components included counseling or therapy services (11%), outings for couples (7%), and providing activities for couples only (3%).

Respondents were also asked to provide information about their facility's activity program as it relates to preserving spousal/partner relationship. Holiday and special event parties were identified most frequently as an activity that might serve to preserve spousal or partner

relationships. Music-related activities and visitation were also among the top selected activities, reported at frequency of 12% and 11% respectively. Additional activities included board games and crafts (9%), religious activities, couple outings, and dinners/meals (8%), anniversary celebrations and group work (3%), special living arrangements (2%), and exercise activities (9%). Approximately 8% of respondents reported none of their activities preserve relationships among spouse or partner couples.

Respondents also shared their thoughts of what an ideal program might look like in the nursing home setting. The most frequently selected service was private meals for residents and their spouse or partner (22%). However, providing activities specifically for residents who have a spouse or partner was not far behind at 21%. Additional selections included couple outings (19%), private time for couples (19%), and counseling and therapy services (15). Some respondents wrote in the following: celebrations of anniversaries, providing psychiatric services for both the resident and their spouse, frequent visitations, allowing residents to share their relationship longevity secrets, and providing grief counseling services.

### **COVID-19 Practices**

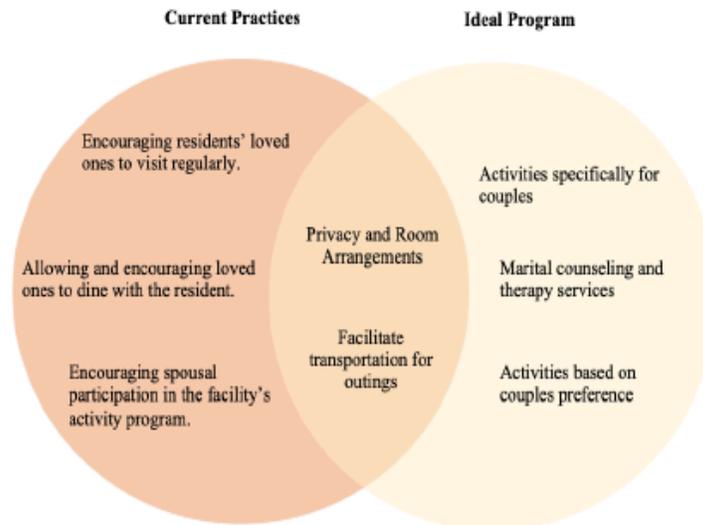
COVID-19 survey section included questions about facility Covid-19 practices/restrictions specifically for residents who have a spouse or partner who also resides in the facility. Although many respondents reported not having spouse or partner couples in their facility at the time of the survey, some that did indicated that spouses and partners were not allowed visit with one another (28%). However, one-quarter of respondents (25%) reported no enforcement of restrictions for this group, allowing spouses and partners to visit with one another as usual. Close monitoring of spousal and partner visits and allowing visitation for a specific amount of time was reported by 11% and 4% of respondents respectively.

## Interview (Qualitative) Results

Participants shared in-depth comments about content similar to questions on the larger survey.

### Facility Practices

Participants were asked to share details about their current programs and practices related to preservation of resident's spousal relationships as well as describe an ideal program. Below is a figure that displays the results and activities that overlapped.



### Barriers to Carrying out Current Practices

Identified barriers in carrying out activities to maintain spousal relationships related to the organized activity programs included limited private areas and rooms throughout the facility, difficult family dynamics, cognitive capacity and ability to consent, physical capabilities of the community dwelling spouse, and attitudes of facility staff.

### Organized Activity Program

these services are to be carried out. Changes in programs and increased conversation in this area will pave the way for changes at the macro level of practice in which social workers might share their own experiences and practice techniques not only with administration to promote program development within their facility, but with nursing home policy makers to encourage widespread policy development throughout each facility.

APPENDIX K: Institutional Review Board Approval Letter

THE UNIVERSITY OF ALABAMA | Office of the Vice President for  
Research & Economic Development  
Office for Research Compliance

July 6, 2020

Shanae Shaw  
Social Work  
Box 870314

Re: IRB # 20-05-3609: "The Preservation of Spousal and Partner Relationships among Nursing Home Residents"

Dear Ms. Shaw,

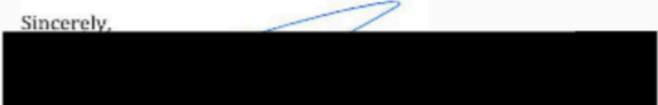
The University of Alabama Institutional Review Board has granted approval for your proposed research. Your application has been given exempt approval according to 45 CFR part 46. Approval has been given under exempt review category 2(iii) as outlined below:

*(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if: (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).*

The approval for your application will lapse on July 5, 2021. If your research will continue beyond this date, please submit the annual report to the IRB as required by University policy before the lapse. Please note, any modifications made in research design, methodology, or procedures must be submitted to and approved by the IRB before implementation. Please submit a final report form when the study is complete.

Please use reproductions of the IRB-approved informed consent form to obtain consent from your participants.

Sincerely,

  
Carpantato T. Myles, MSM, CIM, CIP  
Director & Research Compliance Officer

cc: Dr. Ellen Tsikai

Jessup Building | Box 870127 | Tuscaloosa, AL 35487-0127  
205-348-8461 | Fax 205-348-7189 | Toll Free 1-877-870-3066