

SECTION II

GENERAL INFORMATION FOR COMMITTEES

A. THE ADULT CARE HOME

1. Types of Homes

The three types of licensed adult care homes are:

- a. A family care home provides care for two to six unrelated adults who are in need of care. In appearance, the building is like a house and is usually located in a neighborhood with other houses and families next door. The care provided includes room and board, personal assistance, supervision, and meaningful activities in a family setting.
- b. An adult care home provides care for seven or more unrelated adults who are in need of care. Currently the licensed capacity for adult care homes ranges from seven to in excess of 200. Most adult care homes have a capacity of 40 to 60. The size of the buildings varies, depending upon licensed capacity. The care provided includes room and board, personal assistance, laundry, transportation, supervision, and meaningful activities. *(Could also be referred to as domiciliary care, rest home, or assisted living facility)*
- c. A group home for developmentally disabled adults provides care for two to nine unrelated adults. These are small residences, usually located in a regular neighborhood. Only adults who are developmentally disabled can live in these homes and they must be able to participate in community day activities (such as an Adult Developmental Activity Program, Sheltered Workshop, or regular employment), must be ambulatory and either have or be able to develop self-help skills. The care provided includes room and board, personal assistance, supervision, training, and individual goal planning to help develop self-help skills. Residents are encouraged to participate in community activities and family events to the maximum of their abilities.

2. Types of Residents

Adult care homes are for a population having a variety of conditions: those with mental retardation, the chronically mentally ill, those with physical disabilities, and some, who because of age alone and the lack of social support, require the availability of 24 hour care and supervision.

The ages of the resident population also vary. While a resident must be at least 18 years of age, the population includes younger aged adults, middle aged, and older persons, all of whom need the adult care home level of care and supervision because of their condition or situation.

Some homes, especially smaller ones, tend to care for a particular population, such as older women, the younger mentally retarded, or the chronically mentally ill, etc. Other homes have a mixed population, providing for persons with all types of conditions requiring adult care home level care.

By design, the group home for developmentally disabled adults has a homogeneous population. Even so, there will be variance in residents served according to the type of disability, age, functional capacity, complicating conditions, and other factors.

3. Review of Programs and Services Provided in Adult Care Homes

a. Personal Care

- 1) Assist residents with grooming as well as personal care including bathing, dressing, eating, walking, going up and down steps, correspondence, shopping, and scheduling of medical and business appointments.
- 2) Allow residents freedom of movement.
- 3) Supervise residents who smoke and need supervision.
- 4) Evacuate residents in an emergency.
- 5) Assure that residents are dressed in appropriate clothing when using the living room, dining room, and recreational areas or when out of the home for activities in the community.
- 6) Respond immediately in case of an accident or incident involving a resident. Make a report on the DSS Accident/Incident form.
- 7) Encourage and assist the residents in exercising their rights included in the Residents' Bill of Rights.

In group homes for developmentally disabled adults, staff encourage residents to exercise maximum independence in health, hygiene, and grooming practices, including bathing, brushing teeth, shampooing, combing and brushing hair, shaving and caring for toenails and fingernails.

b. Health Care

- 1) Provide occasional or incidental medical care (such as therapeutic diets, applying heat pads).
- 2) Administer and manage drugs for residents (only drugs prescribed by a physician or other authorized person can be given). Drugs are given to residents by the administrator or other staff designated by the administrator to be capable and appropriately trained.
- 3) Must arrange for appropriate health care as needed to enable the residents to be in the best possible health condition.
- 4) The resident is to be allowed to choose a physician to attend him. Immediate arrangements must be made by the administrator with the resident or his responsible person for the resident to secure another physician when he cannot remain under the care of his own physician.
- 5) Arrange for resident's medical transportation.

- 6) Have first aid supplies available for immediate use.
- 7) Notify responsible people in case of sudden illness, accident or death.

c. Food Service

- 1) Meals are to be planned, taking into account the food preferences and customs of the residents.
- 2) Each resident is to be served a minimum of 3 nutritionally adequate meals a day; suitable foods and/or liquids must be offered between meals; minimum daily requirements must be met (fruits, vegetables, protein, bread, etc.).
- 3) Staff must follow safe and sanitary practices in storing, preparing and serving food.
- 4) Food is to be served at appropriate temperatures.
- 5) Menus are to be planned, in writing, and posted appropriately in the kitchen.
- 6) Table service must be provided and residents are to eat together unless room service is needed (for physical or emotional reasons).
- 7) Special diets are provided when ordered by a physician; menus must be planned and/or reviewed by a registered dietitian.

d. Activities

- 1) Each home must develop a program of activities designed to promote the residents' involvement with each other, their families, and the community. The program is to provide social, physical, intellectual, and recreational activities.
- 2) Each home must have an activity coordinator.
- 3) There must be a minimum of 10 hours of planned group activities per week.
- 4) Activity Coordinator reviews upon admission personal information about each resident's interests and capabilities and records this information on an individualized index card or equivalent.
- 5) A monthly calendar of group activities is prepared which is to be easily readable, in large print and posted in a prominent location in the facility on the first day of the month.
- 6) Facilities are encouraged to involve community resources to enhance activities available to residents.
- 7) Each resident must have the opportunity to participate in at least one activity out of the facility every other month.

- 8) The Activities Coordinator evaluates and documents the overall effectiveness of the activities program at least every six months with input from the residents.

In developmentally disabled adult homes, the residents should have time for social development both individually and in groups; residents should be encouraged to develop their own social and recreational activities; the home should encourage parties, dances, and other social events. Opportunities for activities outside the home such as ball games, movies, and bowling should be offered to the residents.

e. Other Personal Services

- 1) Transportation must be provided or arranged for resident to get to necessary resources and activities; to nearest appropriate health facilities, social services agencies, shopping, and recreational facilities, and religious activities of the residents. The resident is not to be charged any additional fee for this service.

Transportation services shall be available to the developmentally disabled residents, but residents shall be encouraged to use public transportation when available, if the residents are able. Training a person to use public transportation might be necessary to accomplish the goal of independence. This goal may not be possible for every resident due to personality and degree of disability but, when possible, independence and normalization shall be encouraged.

- 2) Mail is to be given to residents promptly and unopened (unless a written request is made); outgoing mail should not be censored. Residents are encouraged and assisted, if necessary, to correspond by mail with close family and friends.
- 3) Laundry service is provided to residents without any additional fee. The residents pay for dry cleaning.
- 4) Telephone must be provided for residents to make and receive calls in a location giving privacy. A pay station telephone is not acceptable for local calls.
- 5) Personal, lockable space is provided for resident to secure personal valuables.
- 6) Visiting in the home and community is encouraged; there must be at least 10 hours each day for visitation in the home.
- 7) At admission, the administrator or supervisor in charge must furnish and review with the resident or his responsible person, essential information about the home. The information must include, at least:

- Copy of the home's resident contract specifying rates for its services and accommodations.
- Copy of any house rules (to include conditions for discharge and transfer, refunds, smoking, alcohol consumption, and visitation).
- Copy of Residents' Bill of Rights.
- Copy of home's grievance procedures (which must indicate how the resident is to present complaints and make suggestions).
- Statement as to whether or not the home has signed the civil rights compliance statement (and if it has not, that residents would not be able to receive Special Assistance and the home would not receive referrals or supportive services from the county department of social services).

f. Special Requirements Applicable to Developmentally Disabled Homes

- 1) Life in these homes shall resemble, as closely as possible, life as it would be in a home with people of normal abilities and shall resemble the life style of persons in the same age group.
- 2) Residents shall be appropriately engaged in competitive employment, a sheltered workshop program (evaluation, training, or work activity) or in an adult developmental activity program or other appropriate community programs.
- 3) Individual goal plans shall be developed with all residents.
- 4) Residents shall have an opportunity to acquire personal skills that will make them more independent and self-sufficient.
 - a) Residents shall participate in ordinary daily chores that relate to family living.
 - b) Residents shall be trained and encouraged to exercise maximum independence in the selection, use and maintenance of their own clothing.

4. Overview of State/County Special Assistance for Adults

This public assistance program is established for the purpose of helping eligible people pay for the cost of adult care home care. The county department of social services receives applications from people, determines whether or not a person is eligible, and if eligible the amount of the payment.

There are two categories: Aid to the Aged and Aid to the Disabled. To receive Aid to the Aged, the person must be 65 years old or older, have countable income less than the current monthly rate for adult care home care, and meet certain other criteria. To receive Aid to the Disabled, the person must be age 18 or under age 65, have countable income less than the monthly rate for adult care home care, be disabled, and meet certain other criteria.

The person must live in a licensed adult care home that complies with civil rights requirements in order to receive Special Assistance for Adults.

B. HOW TO CONDUCT AN OFFICIAL VISIT

Visiting facilities is an important part of the committee's responsibilities; therefore, it is important to do it well. You have a commitment to the elderly to see that the facilities in your area maintain the Residents' Bill of Rights and provide quality care.

If you are to be effective in visiting and complaint resolution, your ongoing presence in the facilities will make you familiar with the staff and residents and will help you build a feeling of trust. Residents and families need to be aware they have a legal right to quality adult care home care, and, therefore, can complain if conditions are substandard.

Reporting your visit is also important. If we are to be advocates for the elderly, it is necessary to record what you see, feel, and hear. Even if you feel all is well, say what is good about the home. Submit completed reports to the committee chairmen so they can give full quarterly reports to the Regional Ombudsman who compiles this information and submits it to the State Ombudsman.

1. Reasons for Visiting

The purpose of your visits are to establish relationships with residents and staff; to gain some understanding of the procedures and conditions of a particular home; and to gather and help resolve violations of resident rights.

2. How to Start

Make sure you have the majority of the committee or quorum of your subcommittee. Do not visit on your own as a quarterly official visit. Visit between the hours of 10:00 a.m. - 8:00 p.m. Introduce yourself to the administrator or person on duty. If the person is new explain your role.

3. What to Look for (General Atmosphere)

Use your senses: smell when you first enter the facility, "feel" the atmosphere, is it relaxed or tense? Are staff smiling or are they overworked and bad tempered? Is there laughter? Good humor? Is it too hot or cold? Is it clean or dirty?

4. How to Look

Do not use a notebook or checklist but write up comments after the visit. Each member of the committee can be responsible to visit a particular part of the facility. If concerned about something, at the end of the visit, find another member to have a look together. However, remember you are not "inspectors" or "regulators."

5. Specific Areas of Concern Related to the Bill of Rights

- a. Does the staff talk courteously to the residents?
- b. Do the residents exercise choice about clothing, religious preferences, friends, activities, etc.?

- c. Is the resident's privacy respected during examination or during personal hygiene activities? A closed door or drawn curtains will shield a resident.
- d. Check to see that the facility's license is posted in a prominent place along with Residents' Bill of Rights, fire certificate and other pertinent codes and regulations.
- e. Ask administrator if there are any special charges for physicians and related services - wheelchairs, walkers, crutches, haircuts, personal laundry.
- f. Ask if all residents receive a written statement of services provided by the facility and these charges. Items covered under Medicare/Medicaid must be clearly indicated.
- g. Resident can refuse to be used as a subject for experimental research which should be documented on the resident's chart.
- h. All medical records are confidential. If investigating a complaint, you must have written consent of resident to look at resident's file.
- i. Chemical and physical restraints can only be used when necessary to protect a patient from injury to themselves and others. Restraints can be used only for a specified time as prescribed by the physician. Physical restraints are blankets, straps, mittens, and denial of wheelchair, anything that limits residents from doing something for themselves that they might do voluntarily.
- j. Observe staff's attitude towards residents and observe resident's response to staff.
- k. Does the resident speak freely with the administrator? Does the administrator know residents' names? Is there a mechanism whereby a resident's problem or complaint can be heard free from threat of retaliation. Residents should feel free to present grievances through the staff, Community Advisory Committee, the Department of Health and Human Services and the County Department of Social Services.
- l. Is there a residents' council? Do residents understand their rights? Is there a family night? Resident newsletter? What social groups are there?
- m. Can the resident make phone calls in private? Receive visitors in private? Do residents receive mail unopened? Are visitors freely admitted? If a visitor is prohibited this must be documented in the file.
- n. The residents can have their mail read to them by the staff; however, it should be opened in front of the person rather than in the office and taken to them already opened by the staff.
- o. Is there access to writing instruments, stationery, and postage (to be paid for by the resident requesting these items)? Does the staff assist in writing and sending mail when necessary?

- p. Residents should manage their own financial affairs unless the authority has been delegated to someone else. The resident has the right to examine the account at any time.
- q. Is there a private room for visits with the resident's spouse?
- r. Do the residents have reasonable privacy in their own rooms? When rooms are shared this is more difficult, but it can be achieved with closed curtains.
- s. In adult care homes residents should have a personal lockable space - a drawer or cupboard accessible only to the resident, administrator or supervisor in charge.
- t. Are their mementos and personal property in the rooms?
- u. Residents should be notified if facility is issued a provisional license.
- v. Is transportation arranged for residents to community resources, medical facilities, religious services, so the resident can enjoy pursuit of community activities? The resident should not be charged a fee for this.

Conclusion

Absorb the atmosphere as you visit; talk to the residents; empathize with them; don't take too long. After a few visits, staff and residents will get to know you and why you are there.

Meet with the other members of the committee to discuss the visit.

Have an exit interview with the administrator or person in charge to let them know your findings- positive or negative. If you find something negative in the home, discuss it with the administrator and arrange a time to come back and check on the agreed upon change. (See the "Complaint Management" section of this handbook for more detailed information about handling complaints.)

If the administrator is not on duty, perhaps one member of the committee can call him the next day to discuss the visit; otherwise he might not know you visited. Most administrators like to know things firsthand, if possible.

Remember you have a right to be there, but do not abuse it. Be courteous at all times.

Committee members are reminded that **any physical assessment of a resident is to be conducted by authorized facility staff and/or appropriate regulatory agency staff only.**

C. ESTABLISHING RAPPORT WITH RESIDENTS

The daily lives of residents can be very different from our own. As a result, it is sometimes difficult for us to begin a conversation with them or know what to do in an unfamiliar situation. Many people are repulsed by what they see in an adult care home. The concentration of older people who have suffered some degree of physical or mental disability may be disturbing to you. Here are suggestions to help you feel more at ease and to make your visits more successful.

1. Understanding Residents

When you visit with residents, there are a few things to consider. First, try to look beyond physical appearances. Think of each of these residents as an interesting individual who has experienced much in life. Each person has a unique personality that is not dependent upon physical appearance. You may be bothered by those who appear to be confused or disoriented. These people often can be reached simply by gently holding their hands and looking into their eyes. Second, independence is very important for their self-esteem, and residents should be encouraged to care for themselves to the extent possible. You should be aware of this goal. If he or she should ask for help, say "I'll be glad to help." But at the same time, encourage independence by having the resident participate. Also, does the resident want a visitor? If they seem withdrawn and not receptive, make your visit brief. A valuable relationship can be developed from short visits over a period of time.

The key to developing a good relationship is to encourage the resident to share his or her feelings. Listening can be difficult, but remember that it shows you care. It is also important that you talk about what is happening in the community. This keeps the resident in touch with the world outside the facility.

2. The Visit

When people visit you, they come to the door and knock or ring the doorbell. A resident's room in a adult care home is home. Knock before entering and ask permission to enter. If the resident is unable to respond, then announce yourself before walking in. Proceed cautiously, do not interrupt the residents' private space abruptly or loudly.

Greetings usually involve some sort of physical contact. Shake hands or touch them on the hand, arm, or shoulder in a warm manner. Adult care residents are often removed from family and friends who provide this sense of touch. Think a moment about what the quality of your life would be if no one ever touched you except to bathe or toilet you. Touching tells us that we are accepted, human, and desirable. Once in the room, make some form of contact unless it is absolutely inappropriate.

3. How to Talk with the Residents

- a. Addressing the resident by name is one of the best ways to begin to establish rapport with them. Find out their names before calling on them. To communicate respect, it is suggested that you use the resident's surname ("Mrs. Smith") unless he/she asks to be called by another name. Of course, you can always ask the residents how they prefer to be addressed.
- b. Communicate respect by requesting permission to engage in conversation. Make it clear who you are and why you are there; ("I am Mary Smith, I've been appointed by the county to help you and the home in giving you the best possible care"). Establish physical and verbal warmth. Let them know you are attentive and interested in them through your body language. Make eye contact, sit facing the resident directly, if possible, and touch when appropriate. Ask about their

contacts outside the home--family, friends, visitors, letters, phone calls, explore their personal history, without prying, to discover their interests. Be honest about your own reactions and feelings. Share with them just as you are asking them to share with you. Remember that some residents may have hearing difficulties; others may have communication problems that require patience.

- c. Encourage reminiscing by asking questions about the resident's life and achievements. (Examples: What is the highpoint of your life? Who was the most important person in your life? What was your favorite food as a child?) Sometimes when the memory is failing, it is easier to remember distant events. The older person naturally wants to discuss important roles they have played and significant happenings in their lives.
- d. Empathize with their feelings of loneliness or distress. Do not try to deny these feelings. Often a sympathetic ear is all that is needed. Try positive reinforcement such as, "It is difficult to adjust to new places." (Recognition and expression help them to accept change.)
- e. Discuss the history of their stay in the facility, and when you have developed an adequate level of rapport, talk with them about their feelings about being in the home. You might not reach this level on the first visit, but it's something to work towards.
If residents express any displeasure or dissatisfaction regarding any circumstances of their lives in the home, try to uncover their whole story. Listen carefully so that you can note down important information later, for reference. Pursue comments residents make--don't let off-hand remarks slide by.
- f. Do not give advice unless asked. Instead, ask their advice or opinion. This helps them to feel useful.
- g. Devise a system for remembering names and something about the person. Perhaps keeping a small confidential notebook in which you jot down a few notes when the visit is over would be a good idea. When you return for your next visit you can then review the names and notes to refresh your memory. The fact that you have remembered something about them will enhance their self-esteem.

4. How to Handle Residents with Complaints

- a. Listen. Listen very carefully to the complaint or complaints.
- b. Evaluate. If everything is wrong, then the resident probably is still adjusting to the home. He or she is probably feeling alienated and uncomfortable in new surroundings. If there are specific complaints listen carefully and try to discern the truth. You may want to talk to the appropriate staff who may not be aware of the resident's concerns. Often, misunderstandings can be cleared up easily. If the complaint cannot be cleared up easily, refer it to the committee chairman.
NOTE: Be sure to get the resident's permission before you talk to anyone about the complaint. Respect their confidentiality.
- c. Explain. When you have reached a conclusion about or a solution for the complaint, be sure the resident understands the explanation. You may have to explain more than once.

- d. Limit. Finally, for the chronic complainer who is never satisfied, set a limit to the complaint time. We all need to vent our feelings and emotions. Then turn to something positive.

5. Points About Communicating with a Mentally Retarded Person

(You will, of course, need to adapt these suggestions to each individual, since every person is different.)

- a. Be sure he is aware that you are speaking to him. This is especially important because, either in an institution or at home, he may often have been a bystander to conversations where his presence was ignored. Saying his name before you speak to him is one way to get his attention. If he doesn't look at you when you speak, encourage him to do so.
- b. Try to use words he knows, don't confuse with too many words and be consistent in using the same words each time you mean the same thing. Don't go into detailed explanations and try to limit what you say to one idea at a time. Get his answer (whether in words or action) and then present the next idea or information.
- c. If possible, help the person to see what you are talking about as well as hear you. For example, you can often pantomime what you want (in fact you may already do this without even thinking about it). Or you may be able to demonstrate what you mean at the same time that you explain it.
- d. Allow a bit more time for him to react than you would with most people. You will soon learn how much time is needed for each person.
- e. If someone's speech is hard to understand, don't be afraid to ask him to slow down or repeat. Do this courteously as though asking a favor, because you really do want to understand. Some of us feel more at ease saying, "I don't understand you" rather than, "You don't talk well." Another way to help is to repeat what you think you hear and ask the person if you are right. Or ask if he can show you what is on his mind. You will often find that another resident can interpret for you. If in spite of everything you still don't understand, or the person seems angry or ready to give up, reassure him again that you wish you knew what he was saying, and let the matter drop. Don't despair; you will soon find it much easier to know what is being said.

Conclusion

Visiting should be pleasant for you and the resident. Plan ahead, be polite, remember to touch when it is appropriate and above all, keep a good sense of humor.

D. THE AGING PROCESS

1. Biological Aspects of Aging

Knowing what physical changes are inevitable in the aging process will help an older person to deal with them, and will help the community advisory committee member to better understand the needs of the adult care home resident.

The human body is made up of cells which in turn form the tissues, organs, and bones. These cells are constantly being created, developing and dying, and new cells are created to replace them. In an aged person, the cell regeneration rate appears to decrease and a slowing down of biological functions and reduction in reserve follows. The person will usually show some of the following signs of aging:

a. Skin and Appearance

The skin loses some of its elasticity, and becomes dry and wrinkled because the sweat and sebaceous glands function less effectively. As the circulation of the blood to the skin slows, cold is felt more readily. With aging the skin becomes thinner and may be more susceptible to being broken or cut. When broken, the skin may be susceptible to infection.

Changes in the face appear. The loss of teeth causes a shortening of the lower part of the face, while the nose lengthens. Hollows may develop beneath the eyes. The hair whitens and thins. In our youth-oriented society, the beginning of any of these changes can seem a terrible threat.

b. Bones

As a person becomes older, the bone mass decreases by as much as 10 percent after the age of 45. For example, the spinal discs in the backbone compress, causing a bowed back. In addition, the bones lose elasticity and become more brittle, making breaks more likely. There may also be slight changes in the bone angles, causing new stresses and a higher probability of breaks. These changes make an older person more vulnerable, perhaps more cautious in moving around and hesitant about traveling.

c. Senses and Reactions

The senses -- hearing, sight, taste, smell, and touch -- become less sharp with age because of the decreased number of cells in these systems. In addition, there is a general slowing down of responses to stimuli. Rapid, voluntary movements are not performed as quickly. The muscles are slower and less precise. The balance is not as acute.

Any of these changes may produce a chain of crises in an older person. For instance, as taste and smell diminish, food becomes less appetizing. If a person eats too little or improperly, mental confusion may result and meals may be still more neglected. A downward cycle of malnutrition, inactivity, and disorientation follows. Or an aging individual may experience a loss of coordination, causing him/her to fall often, which causes him/her to withdraw from community activities, which in turn means loneliness, depression, lost appetite and vitality.

All of these changes are hard to bear. Nonetheless, in many cases the changes need not impair behavior. An older person does not have as much physiological reserve as a younger person, but most stimuli are far above the ordinary thresholds of perception anyway, and people do not often operate at the limit of their capacities. An active life-style is still possible, particularly if an older person adjusts creatively to those changes and losses that have occurred, and combats

the aging process with proper nutrition, regular exercise, and a vigorous interest in the world around him/her.

2. Psychological Aspects of Aging

a. Memory and Learning

Memory and learning involve our ability to register, retain, and recall experience. Under most circumstances, age-related changes in the primary ability to learn appear to be small. However, there may be problems in sensory perception, control of attention, motivation, or poor general health. In addition, with the general slowing down of responses that come with aging there may be a reduced capacity to handle complex activities and unfamiliar tasks. But usually learning ability does not slack off, especially in those who continually exercise it.

b. Mental Illness

One of the most myth-shrouded areas of aging is that of mental illness. For many years, senile brain deterioration has been thought of almost as a normal result of the passage of time. It is true that brain disease in late life occurs more frequently than do the mental illnesses of early life. Even so, only a very small percentage of the total population may be expected to be institutionalized for mental illness late in life.

Further, it has been found that mental illness in older persons can occur as a side effect of physical illness. Infectious diseases and malnutrition can cause mental symptoms that remain long after the original condition is controlled.

Gerontologist Dr. Robert N. Butler, in his book Why Survive? Being Old In America, discusses "the myth of senility":

The notion that old people are senile, showing forgetfulness, confusional episodes and reduced attention, is widely accepted.

'Senility' is a popularized laymen's term used by doctors and the public alike to categorize the behavior of the old. But anxiety and depression are also frequently lumped within the same category of senility, even though they are treatable and often reversible. Old people, like young people, experience a full range of emotions, including anxiety, grief, depression and paranoid states. It is all too easy to blame age and brain damage when accounting for the mental problems and emotional concerns of later life.

c. Attitudes Toward Death and Dying

Are elderly persons inordinately anxious about death? According to stereotype, yes. But the fact is that younger persons are more likely to be concerned about death. Older persons are probably more worried about money.

One study comparing interviews with persons who died within the year and interviews with those who survived the year revealed that the individuals closest to the time of their death showed a much greater interest in their immediate environment. This suggests that isolation is a great disservice to the dying. To deny the dying person access to others and to a normal, stimulating environment would seem to reduce the likelihood that he/she will resolve his or her own

departure with dignity. Isolation of the dying may be a reflection on the attitudes of younger professionals who are disquieted by their own unresolved conflicts.

d. Some Characteristics of Older Persons

Society often tends to lump older persons together psychologically in a discriminatory way -- "He's getting old and senile," "You can't teach an old dog new tricks," or "Old people live in the past." This is ageism. It is important to recognize there are great varieties in character, ability, interests, and personality among older individuals. Nonetheless, gerontologist Dr. Robert Butler lists ten late-life characteristics which tend to appear frequently among older persons:

- Change in the sense of time. Since the future is short, some retreat to the past. Others emphasize the importance of the here and now, of living in the moment.
- Sense of the life cycle. Older persons can experience in a personal sense the entire life cycle.
- Tendency toward life review. The realization of approaching death stimulates older persons to relive and review their past experiences. Through this process, they may resolve troubling conflicts and fears. Attentive listeners may help older persons to recount their lives.
- Reparation and resolution. Older persons may feel guilt for and try to atone for past actions.
- Attachment to the familiar. Familiar objects facilitate the life review and provide a sense of security.
- Conservation and continuity. The old have the opportunity to pass on knowledge to younger generations.
- Desire to leave a legacy. Older persons are concerned about leaving something behind when they die, be it grandchildren, possessions, or a work of art or social import.
- Transmission of power. One of the psychological issues of old age is when to surrender one's power and authority to others.
- Sense of fulfillment in life. Some older persons experience a sense of satisfaction and pride upon looking back over their lives.
- Capacity for growth. The capacity for creativity and wonder need not decline with old age.

3. Age Related Sensory Changes

a. Vision

1) Behaviors which may indicate visual problems:

- Coordination difficulties

- Positioning of objects
- Squinting of eyes
- Color selections
- Uncontrolled eye movements
- Depth perception
- Inability to cope

2) Helping older persons with visual problems:

- Positioning of objects in visual field
- Labeling objects - use large lettering
- Simplify the visual field - remove objects that are cluttering the area
- Consistently position objects - do not move or rearrange objects
- The use of bright colors
- Give pre-warning - announce to person what you are going to do
- Helping to use other senses as compensation

b. Hearing

1) Behaviors which may indicate hearing loss:

- Increased volume of speaking
- Positioning of the head
- Asking for things to be repeated
- Blank looks and disorientation
- Isolation
- Attention span
- Not reacting
- Emotional upset

2) Communicating with those with hearing problems:

- Face the person - allow him/her to read lips
- Make sure he/she is aware that you are addressing him/her - touch person to ensure having attention
- Speak slowly and distinctly
- Use short sentences
- Give short explanations - ex. I like to shop at Food Town, the grocery store
- Do not repeat same phrase over and over - use different expressions until one point gets across. Ex. I have a cold. I am sick. I do not feel well, etc.
- Do not shout, lower pitches may be clearer
- Use gestures and/or objects which illustrate verbal message. Ex. point to direction
- Attempt to speak in ear in which person retains the best hearing.
- Avoid standing in front of window or other light sources. The glare from behind makes it difficult to read lips.

- If person has a hearing aid, make sure it is used, or find out why not.

c. Touch

1. Behaviors which may indicate tactile loss:

- Avoidance of touching
- Extremes in recognizing pain
- Oral exploration
- Not responding
- Grasping

2. Assisting person with tactile loss:

- Use touch therapy - communicating through touch
- Talk - tell person what you are doing, helps him/her to use multiple senses
- Gripping - make sure person has adequate hold on object
- Pressure - increase pressure when touching someone

d. Taste

1. Behaviors which may indicate taste changes:

- Loss of, or increased appetite
- Complaints about food
- Questions about food person is eating
- Tongue coating
- Excessive seasoning

2. Making food more appealing:

- Food presentation
- Separating food
- Texture of food
- Mouth and dental care;
- Taste parties.

e. Smell

1. Behaviors which may indicate olfactory changes:

- Not reacting;
- Congestion;
- Persons says he/she can't smell objects;
- Increased body odor.

2. Helping person compensate for loss of smell;
 - Allow person the opportunity to smell food before it is placed in his/her mouth;
 - Explain what food has been prepared - person thinks of smell; and
 - Label items which look alike so person can use other senses to compensate.

f. Mobility and Balance

1. Behaviors which may indicate mobility limitations:
 - Poor posture
 - Dizziness
 - Gait
2. Helping person to maintain or strengthen the capability of movement:
 - Support person on the side that needs support
 - Assist person in standing
 - Teach person to grasp you for support, rather than you holding them
 - Carefully check to insure that any hazards, such as trashcans or foot stools, are removed from the path of the older person
 - Be patient, some older people do not move as rapidly as some younger people.

E. ALZHEIMER'S DISEASE

Alzheimer's Disease, named for the German neurologist who first described it in a 51-year old patient in 1906, is a widespread but little-known brain disorder. Alzheimer's causes progressive memory loss and ultimately, death.

Many victims cannot be left alone. Their wanderings and forgetfulness -- often unknown to outsiders -- make extraordinary demands on their families and other caregivers.

Alzheimer's most often strikes the old, but it may also affect persons as young as 40. An estimated one-half of all cases of pre-senile and senile dementia -- "senility" -- stem from Alzheimer's.

Diagnosis, though increasingly sophisticated, still depends on painstaking elimination of other possibilities. Currently, no effective treatment for Alzheimer's exists.

The cause is unknown. Specialists now believe heredity, once the number one suspect, accounts for a small percentage of suspected Alzheimer's cases. Alzheimer's does not usually affect more than one member of any family. Researchers have turned their attention to viruses, environmental toxins and changes in brain chemistry.

One theory: Nerve endings in the outer layer of the brain degenerate and disrupt the passage of signals between cells. When the brains of Alzheimer's victims are examined at autopsy, two types of microscopic abnormalities -- called plaques and tangles -- characteristically appear.

From onset of symptoms, Alzheimer's can last anywhere from three to 20 years or more. It always ends in death.

Sources: Triad Alzheimer's Association Chapter and
Duke Alzheimer's Family Support Program.

F. MENTAL RETARDATION

Mental retardation means significantly subaverage intellectual functioning existing concurrently with limitations in two or more adaptive skills areas and manifested prior to age 22. An intelligence quotient of 70-75 or below, as measured on a standardized test, is considered "significantly subaverage."

Persons who have mental retardation experience difficulty in learning and performing certain daily life skills. Deficits may occur in any of these life skill areas: self-care, communication, self-direction, health and safety, academics, leisure, work, social adjustment, and use of community resources.

However, almost all persons with mental retardation will improve in their functioning when appropriate supports and services are in place.