CMHC nursing home and hostels
design guidelines study

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WORKING PAPER # 3

PROGRAMS AND SERVICES IN NURSING HOMES AND HOSTELS

CHMC NURSING HOME AND HOSTELS
DESIGN GUIDELINES STUDY

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CMHC NURSING HOME AND HOSTELS DESIGN GUIDELINE STUDY

Working Papers

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PROGRAMS AND SERVICES IN NURSING HOMES AND HOSTELS

TWO CATEGORIES OF PROGRAMS AND SERVICES:

The various programs and activities implemented in a hostel or nursing home, fall into two distinct categories. These are:

- Physical Care Services
- Psychological and Social Care Services

PHYSICAL CARE SERVICES:

Definition:

The first of these categories contains general administrative and health maintenance services, and focuses on physical needs of the resident. Services of this type include administrative, staffing, dietary, housekeeping, medical, fiscal, and maintenance functions of the institution. These activities are well-defined, and receive prominence in the education of staff members and in the design of the facility itself.

Only to a limited extent do the general administrative, maintenance, and medical procedures in various facilities differ from a basic institutional pattern. Of necessity, certain adjustments are made, in nursing homes and hostels, which take into consideration the particular needs of the institutionalized elderly person, and these changes tend to be of a specific type. Those that are most usually made will be described here, and recommendations will be made at the end of this section which suggest further changes that might be made to improve physical care services, in view of the total care needs of the resident. How the physical environment may be specifically adapted to facilitate these improvements will be discussed later in the design section of this report.

Medical Services:

By definition, the resident of a nursing home or hostel suffers from some degree of physical or mental impairment, but is not in a position to require acute care. (See WORKING PAPER # 5: Definitions of Levels of Care, Nursing Homes and Hostels). Therefore the extensive and sophisticated facilities found in a general hospital are rarely provided in a hostel or nursing home. The medical facilities of these institutions are focused less on situations of medical crisis, and more on the problems of health maintenance. In terms of the elderly resident, health maintenance describes "goals and services related to disease prevention and the promotion and maintenance of maximum independence of function." More specifically, these services utilize "such techniques and programs as disease detection (periodic health examinations, multiphasic screening), immunizations, mental health programs, accident prevention and health education." [1]

To allow this emphasis, and in view of the possibility that facilities for acute care may sometimes be needed, geographic proximity to a general hospital, special medical services and professional (doctor, dentist, etc.) offices, are considered desirable. When medical relationships of this type are possible, it is unnecessary for the nursing home or hostel to offer duplicate services, and only specific facilities and equipment need be made available.

Medical Services in Nursing Homes:*

Of the various medical service areas that could be considered necessary to meet the needs of a nursing home, the following may be listed:

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* Most of this information was obtained from John Barrett, Hospital Consultant, Cluff & Cluff Architects. Much of it, for example the number of residents to be considered in each aggregation or cluster, may have to be re-evaluated in the future.

A. Supervision Area:

This area functions as a home-base for each cluster of 40-60 residents. It is established for use by both non-professional and para-professional staff and for those performing clerical and administrative functions. It may include:

- an enquiry point
- a writing/typing area
- a chart/record filing space
- an audio-visual answering service
- a message centre

The possibility of a retreat space adjoining the relatively open reception/clerical area should be considered. This space would be used as a nurse's room and allow the R.N. to carry out those tasks that require privacy.

B. Pharmaceutical Area: *

This area should contain a secure drug space which is visible from the adjoining nurse's office but not accessible from the corridor. Beyond this, requirements for pharmaceutical space vary from facility to facility. By one estimate a facility of 150 to 200 beds or more justifies the inclusion of a self-contained pharmacy and the services of a full-time pharmacist. For smaller units, a consultant pharmacist is considered sufficient. [2]

C. Examination/Treatment Area:

One examination/treatment area should be allowed for each 40-60 cluster of residents, and should be centrally located within each such grouping. This space could be divided into two rooms: one to act as a specific examination/treatment area, and the other as a space reserved by the doctor for interviewing and consultation. The examining or treatment room should allow for a private dressing space, storage and other facilities, including:

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* This area may not be considered necessary for levels I and II care.

- an examining table
- standing blood pressure unit
- electrocardiogram machine
- diathermy machine
- scale
- sink with foot pedals
- examining light
- medical supply cabinet [3]

If it is not practical to provide for a separate doctor's office, then the examining/treatment room will also have to be adjusted to accomodate the doctor's other activities. In this case a writing surface, and possibly a room-divider would also be provided. In addition, this examination/ treatment area must be accompanied by a residents' waiting area.

D. Multi-Use Office:

The question of a separate doctor's office brings to attention the problem of space to be allowed for any visiting professional or para-professional necessary to the care of residents. Consulting dentists, social workers, lawyers, and clergyneed a place to carry out their function, as does the regularly visiting physician. It seems obvious that such a space must be made available if the doctor's office is combined with the examination/ treatment area, and that even if a separate doctor's office is allowed, an additional multi-purpose office would be highly desirable.

E. Medical Segregation Area:

Even with the understanding that residents suffering from acute conditions will be transferred to facilities providing hospital care, instances inevitably arise in which it is necessary to isolate the resident with acute medical needs. It is suggested that a controlled environment of this nature be set aside on the basis of two beds for every 40-60 resident units, with the absolute minimum for any facility of smaller size to be one room and one bed. Of course, it should be repeated that facilities of this kind are contingent on proximity to more extensive medical facilities. As with all of the medical spaces described above, they are defined on the condition that considerable access to specialist and acute care facilities be made available.

Medical Services in Hostels:

The extent to which medical services should be offered in hostels has been a subject of some debate. In the United States, for example, studies undertaken by M. Powell Lawton have concluded that among residents of "congregate facilities," "...the most striking finding was the very high level of expressed need for some kind of regular on-site medical services... Almost two-thirds of all tenants expressed such a need." The reason for this need he observed:

> "...is the feeling of security that is conveyed by knowing that assistance is quickly available if one needs it. Therefore, the most generally approved form was an on-site medical clinic, with regular physician hours and with a nurse readily available. There was less general approval of more clearly hospital-like facilities such as an infirmary or a semi-permanent special care area within the housing." [4]

There is difficulty, of course, in transferring the term "congregate housing" to the Canadian scene, and it is still more difficult to identify the medical services actually provided in Canadian hostels. As Marilyn Whitaker has observed:

> "The extent of medical facilities in these projects varies considerably. In several projects, a nurse may be present and a doctor is on call but the staff and facilities are not available for caring for patients with serious long-term medical needs. Residents with such needs have to be transferred to nursing homes and hospitals. In other projects, residents requiring extensive medical care can be looked after." [5]

Undoubtedly, the fluctuating and often deteriorating health characteristics of elderly people are responsible for this variety and ambiguity in services. One of the most pertinent factors to be considered when planning for the administration of medical care for the aged is that successive transfers from one level of care to another are likely to occur. Medical services in any institution for the elderly must be planned to appreciate and ease these transitions. In a hostel in particular, this task may be difficult.

Whitaker noted, for example, that "Projects which originally had no medical facilities...now have some medical services because it was realized that the need for such services was greater than originally expected or because of requests from residents." [6] The exact details of these various services, such as were obtainable on nursing homes, are difficult to establish.

How Extensive Should Medical Facilities be in Nursing Homes and Hostels:

This is an area of great debate. Much depends on each individual institution's admission policy and the scope of care for which it defines itself. Nursing homes and hostels now operating in Canada offer a variety of medical care services. Recommendations have been made that levels of care be further defined, and that the services offered in nursing homes and hostels be restricted to only one or two levels of care. Weber and Larsson (see WORKING PAPER #5, Definitions of Levels of Care), suggest that hostels house only those residents requiring "supervisory care", and the nursing homes restrict themselves to persons needing "limited personal care" or "intensive care". They describe those requiring a high degree of professional attention, and extensive medical facilities, as being in need of "hospital care". [7]

Even these recommendations however, do not deal specifically enough with the problem of extent of medical facilities, or with the problems of medical transition. On these issues Whitaker again notes "some disagreement", and observes:

> "Many residents do need increasing health care and one view is that it is less traumatic for these people if they can be simply moved to another part of the building rather than to an entirely different building. One administrator says that residents do find it reassuring to know that they can remain in the building where they have friends. The opposite view is that it is nearly as traumatic for a person to move to the medical floor as it is to move to another building. The resident realizes that he is no longer considered healthy and capable of looking after himself. In addition, the administrator of one project with extensive medical services says that the presence of a medical floor has a depressing effect on all residents since they are regularly reminded of the way they might become in future." [8]

In conclusion, she suggest that if persons who are senile or physically incapable are to be accomodated in a nursing home or hostel, then they should be kept separate from the more alert or capable residents.*

Dietary Services:

Dietary services in homes for the aged are distinguished from similar operations in other institutions by several factors. The first of these is the specific psychological importance of mealtimes for the institutionalized elderly, and the second is the higher incidence of a demand for special diets in nursing homes and hostels.

The Psychological Importance of Mealtimes for the Elderly:

In the restricted world of the institutionalized elderly person, mealtimes take on a special significance. Regretably, reports of days spent in anticipation of the next meal, or in discussing the last one, are often true. For many residents, mealtimes are the major social event of the day. Often they serve as reassuring sign posts of the rhythm of daily life for the alienated or confused resident, and often mealtimes are the only organized opportunies for social interaction and conversation provided by the institution.

Food Services in Nursing Homes:

The Social Aspect:

In some institutions an attempt is made to develop the social aspect of dining for the elderly residents. In these situations attention is paid to making the dining area comfortable and accessible, particulary for those residents whose mobility is reduced by a wheelchair or walker. Faced with difficulty maneuvering in a crowded or poorly designed dining room, such persons may find themselves restricted to eating in their rooms, removed from the social opportunities of group dining. The specific factors that must be considered to facilitate this accessibility are discussed later in the design section of this paper.

* This is a debatable issue, however, and some think that a degree of interaction allows for a potential upgrading of the individual on the low end of the performance scale. Ratio of one group to another is the large question.

Other factors to consider when attempting to enhance the social functions of mealtime, and when attempting to reduce the sense of "institutional feeding" present in some nursing home dining rooms, are:

A. Table Groupings:

- do residents have a choice of table arrangements to suit their personal needs?

B. Food Choice:

- do residents have an opportunity to select different items from the menu? (In certain cases, a degree of buffet or cafeteria service can increase the degree of choice).

C. Scheduling:

- is there any flexibility in meal scheduling? Do residents eat at certain times, and within a certain time period? Are residents able to come for meals at different times, and are they able to leave when they are finished?

D. Dining Groups:

- are confused and mentally alert residents fed in the same dining area, or are they fed separately? (NOTE: The Associated Senior Executives of Ontario recommended in Building Better, that some degree of segregation between these two groups be implemented).
- are persons on special diets or in wheelchairs able to eat with the other residents, or must they eat at separate tables?
- what criteria are used to decide if a particular resident should eat in a group dining area or in his room? Are the social aspects of communal dining sufficiently perceived?

E. Dining Room Service:

- is every attempt made to ensure that hot foods are served hot, and that cold foods are kept cold?
- is the dining room well staffed, and do the staff have enough time to speak to the residents while serving or assisting them? Is staff/resident contact personalized?

F. Physical Factors:

- is sufficient space allowed:
  - for storing canes and walkers?
  - for wheelchairs to maneuver?
  - for the staff to serve food comfortably, without inconveniencing themselves or the residents, and without bumping into furniture?
- are tables designed to allow wheelchair residents to move close enough to the table that they don't have to worry about spilling food in their laps?
- are chairs well-balanced and easy to move?
- is an attempt made to control background noises that might make listening and speaking difficult?
- are tables of the right size to provide comfortable conversational distance? (one to two arms' lengths).
- is the environment stimulating to conversation? (This may be introduced through the decor, table and floral arrangements, etc.. Also in some nursing homes announcements are made at mealtime, and mail is distributed). [9]

Alternatives to the Central Dining Room:

If a serious effort is made to enhance the social aspects of dining, it is obvious that as many elderly residents as possible should be encouraged to eat in a group situation, rather than alone in their rooms as is often the case. It may even be necessary to re-evaluate existing criteria used to determine whether or not a particular resident should be fed in his own room or in a communal dining area. For example, a greater effort may have to be made to bring the less mobile residents to the dining room, despite the fact that it may require less apparent effort to bring the meal to the resident.

There are, of course, certain situations in which it is necessary that a resident have his meals made available to him in his own room. When a resident is either unwell or contagious, for example, a private meal

service should be implemented, and every attempt must be made to ensure that the food served to him privately is of the same quality (i.e.,hot meals are kept hot while they are being transported, and cold foods are kept cold), as that available in the central dining area.

In addition to the sick resident, the well resident may feel at certain times that he simply wishes to be alone. On these occasions, or in cases where he finds it more convenient to have specific meals, for example breakfast in his room, these should be made available. It is to be hoped, however, that he does not avoid the central dining room because of unpleasantness he associates with it, or because he feels group dining has nothing to offer him.

Several Dining Areas:

It is possible in a larger institution, for example, that the mere size of a central dining area may overwhelm all attempts to present mealtime as a social experience, or to reduce the institutional aura. In such cases it may be expedient to "regionalize" dining areas throughout the institution, perhaps to a size in which it is still possible for each resident to know each person sharing his mealtime.

Kitchenettes:

Not as much alternatives to the central dining room as complementary facilities are shared kitchenettes dispersed among the residential areas of some nursing homes. These facilities allow residents a degree of flexibility in their eating patterns not always possible with scheduled meals, and allow them to exercise a fundamental degree of self-maintenance. The equipment in these kitchenettes is usually simple, but the option to be able to prepare a snack, a cup of tea before bed, or to offer guests refreshments is important. It should be noted, however, that facilities of this type are found much more frequently in hostels than in nursing homes.

The Problem of Special Diet:

In addition to the design implications of the psychological significance of mealtimes for the elderly, the designer is also forced with other more prosaic space problems. The most important of these is the extra space that must be allowed for the separation and preparation of special geriatric diets.

The most common of the special diets prescribed for elderly people are:[11]

A. Diabetic Diets

B. Low Calorie or Reducing Diets

C. Restricted Sodium Diets

D. Restricted Residue, Gastric, or "Ulcer" Diets

E. Restricted Fat Diets

F. Soft Diets

There are difficulties in designing a food preparation area that can be adaptable to the preparation of such a wide variety of diets. The situation can even be further complicated by the fact that some residents may be assigned to several specific diets simultaneously, soft and diabetic, for example. Also, one of most striking factors of all the diets is that they totally ban certain foods, and that these foods are different for each diet. In a situation like this, space must be allowed for separate storage, cooking, and preparation of different types of meals and the system extended to include the transportation and presentation of all food. These precautions are essential as mix-ups can be dangerous.

Food Services in Hostels:

One of the defining characteristics of a hostel is that meals are made available to residents. In fact, CMHC Consultant George Hart describes hostels as "boarding residences, which offer meals, but no services. These include: care homes, group homes, and halfway houses." [14]

As a rule, however, food programs in hostels offer a greater variety in delivery than in nursing homes. Because a hostel resident is usually able to exercise a greater degree of self-maintenance than a nursing home resident for example, facilities for independent preparation of food are more likely to be found in a hostel than in a nursing home. As one author has observed:

> "Requiring a resident to take and pay for (in effect, involuntarily) three standard meals a day will overinstitutionalize the setting. Only the very dependent will sacrifice the freedom to prepare their own food at least occasionally. Eating is a social event, and the opportunity to prepare one's food facilitates small group gatherings, reciprocal dinner invitations, and similar socially beneficial activities". [15]

Communal eating facilities are also offered in most hostels, either in the form of a cafeteria or a dining room, similar to that found in a nursing home. The advantage of the cafeteria system is that it is possible to offer a wider variety of food than in the standard one menu dining room. The disadvantage of this system, according to one source, is that, "half of the residents of the hostels cannot manage the food trays so that an extra person has been hired to take the trays to their table". [16]

Housekeeping/Maintenance Services:

In both hostels and nursing homes the tasks of housekeeping and maintenance are similar to those practiced in other care or protective institutions. Certain characteristics of the elderly, the tendency towards incontinence, and the decline in their abilities of self-care, for example, create special

housekeeping/maintenance concerns. On the whole, however, these services tend to follow standard institutional practice. In nursing homes the only particular questions are ones of delivery, and in hostels the main question is one of degree.

Housekeeping/Maintenance Services in Nursing Homes:

As a rule one set of separated clean and soiled holding areas should be allowed for every cluster of 40-60 residents. The clean holding space should be reserved for all clean linen and dressings, and might hold the most basic clean supplies, such as toilet paper, and towels. The soiled holding space should contain a sink, a counter, and a bed-pan washer of the sterilizer type. It should also be used for storing of soiled linen, towels, etc.. In addition, a housekeeping or janitorial space should also be allowed on the basis of one per cluster or for every 10,000 square feet, whichever is less. In this area the general housekeeping and cleaning supplies may be stored, and a flushing floor sink, serviced by hot and cold water should also be included. Mobile cleaning units should also be considered to allow for quick emergency clean-ups. For the same reason, "regionalized" laundry rooms should be provided, each to contain washing machines, a dryer, at least two sinks, and a table for folding linens. [17]

Housekeeping/Maintenance Services in Hostels:

In terms of basic facilities, a hostel should provide services similar to those in nursing homes. In situations in which residents are expected to be at least partially self-maintaining however, the question of housekeeping service becomes more difficult. In practice, the degree of housekeeping assistance is largely determined by the resident profile, and this in turn, is governed by admission policy. In some facilities a daily maid service is offered, but in most help "generally consists of dispensing clean linen and weekly cleaning and vacuuming of individual rooms. Assistance is given to people who need help in making beds or changing divans". [18] Marilyn Whitaker has also observed that:

> "While many people do not require such complete service, the study by the Canadian Council on Social Development found that one-third of residents had difficulty doing housework. For this reason, maid service should be considered for future projects". [19]

Administration:

The most distinct facet of the administration of extended care institutions lies in the particular circumstances under which the individual enters and leaves the institution. For many people, the nursing home or hostel may be the place where he lives out the last years of his life, and most residents are aware of this fact. The psychological significance, for both the elderly person and his family, of the moment when he is placed in a home for the aged has been widely documented. Pre-admission anxiety on the part of the resident, and post-admission guilt on the part of the children and family are problems to be considered by the administrator.

There are things, however, that the administrator can do to ease the strain. Studies have shown, for example, that efforts made to promote the physical and social integration of the institution with the rest of the community can do much to alleviate the anxieties of both the resident and his family. Day-care centers and sheltered workshops located in the nursing home, but available to persons still residing in the community, can provide a unique opportunity for the potential resident to be gradually assimilated into the facility, and allow him or her to avoid a sudden and traumatic break with his/her environment. The inclusion of the elderly non-resident in programs organized by the institution, including rehabilitative, social and recreational activities, need not require great changes in physical structure as much as changes in administrative attitude. To facilitate such programs and activities the nursing home or hostel may find it necessary to undergo a re-definition from a self-contained and "closed" institution to a new concept of the home for the aged as a resource facility.

Day-Care:

From the strictly administrative standpoint, the purpose of day-care programs is to allow aging members of the community to maintain themselves independently, or in a relative's home, as long as possible, and to reduce the burden of residential care. It has been pointed out that many persons now in nursing homes, for example, do not require extensive care, and as such, imply a waste of the facility's resources. Leo E. Gottesman and Norman C. Bourestom, for example, have discussed the integration of the nursing home or hostel's resources, and the rest of the elderly community, and have suggested that:

> "...rather than wasting staff and physical plant resources by spreading them over 24-hour, 7-day care, we can organize them to provide at once a more efficient use of resources and a more humane kind of care". [20]

Perhaps even more significant than the administrative advantages of day-care programs, are the social and psychological advantages that these programs offer to both the elderly person and his family.

Louis Novick, Executive Director of Maimonides Hospital and Home for the Aged, in Montreal, has written extensively about the day-care program developed in his facility. One of the primary purposes of day-care services, he believes, is that they "encourage the relatives with whom these patients live to continue maintaining them at home." [21] The day-care program is able to do this, he maintains, because:

1. It relieves these relatives altogether of the burden of caring for the patients during those hours that the latter spend at the day hospital, thus enabling the relatives to relax and replenish their energies.

2. By helping the patients utilize their remaining abilities more effectively, by meeting their need for acceptance, and by maintaining their physical health, it enables them to function at a more adequate emotional and physical level, thus reducing the problems involved in caring for them at home.

3. It makes available to families a trained social worker with whom they can discuss problems as required. [22]

Elderly people still residing in the community are brought by bus to the facility two days a week, six hours a day from 10:30 a.m. to 4:30 p.m.. The daily program focuses on seven areas. These are:

1. Awareness of time, place and person.
2. Memory of recent and remote events.
3. Awareness of body.
4. Carrying out various functions independently.
5. Utilizing old skills.
6. Socializing.
7. Fine and gross motor coordination.

In an attempt to deal with each of these areas, the elderly people are encouraged to participate in:

1. Group activities collectively called "intellectual retraining" activities (also known as "reality orientation").
2. Activities related to the kitchen.
3. Various arts and crafts activities.
4. Recreation activities.
5. Self-care activities.
6. Group physical exercise.
7. Attending the various medical services of Maimonides for treatment.
8. Activities related to the dining room.
9. Travelling in the chartered bus of the day hospital. [23]

Such programs, which are at present in operation in only an exemplary minority of Canadian institutions, will necessitate an administrative adjustment to the new phenomenon of transitional intake, and to the introduction of liaison as well as strictly administrative duties.

Adjustments in physical design and in staffing will also have to be made to accomodate more day-care programs in the future.

Other Administrative Possibilities for Community Integration:

As a matter of administrative policy an attempt can be made to promote community interaction through volunteer programs or by organized recreational and religious excursions into the surrounding milieu.

Physical factors of course can also be crucial. To a large extent the maintenance of successful contact with the community depends on basic location. The availability of public transport is essential to the residents, and no less to their visitors. Accessibility to social, cultural, and spiritual facilities is equally important, and would not even need mention if so many facilities were not lacking in this respect.

In addition, more effort will have to be made to make the home for the aged a receptive environment for visiting members of the outside community. Something more than the frequently isolated "visitor's room", usually off-limits to residents, is needed. More flexible visiting hours, playrooms for visiting grandchildren, and even toy boxes, could contribute to a more relaxed atmosphere.

Conclusion:

In discussing the administration of facilities for the elderly, an effort has been made to identify similarities between nursing homes and hostels. The focus here has been on community integration as a way of lessening traditional adversities associated with institutions for the elderly. In view of this focus it seemed important not to make any differentiations as the object seems no less necessary for one type of institution than another. And in the end the problems of continuity and integration have been included in the discussion of administration as it seems obvious that without administrative support neither object can be achieved. As a last word reference should be made to the advice of accomplished gerontologist, Francis M. Carp, who has written that:

> "Whenever possible, the delivery of services should be arranged in conjunction with available community resources. The formation of working relationships with agencies, such as health and welfare councils, health care programs, and area agencies on aging, should be encouraged. Coordination activities might include joint planning, information sharing, and agreements for joint funding and operation of programs...although the supportive services which are essential to congregate housing are intended to assist the resident population, they should be extended to elderly persons in the community whenever possible. In so doing, costs to residents of the project can be reduced and broader community support for the facility will be generated. Similarly, on-site supportive services should be developed in such a way as to complement community resources rather than duplicate or overlap them." [24]

This seems to be the trend in services for the future.

PSYCHOLOGICAL AND SOCIAL CARE SERVICES:

Definition:

The second category of programs and activities deals with the intricate psychological and social needs of the resident. Services of this type tend to deal directly with the resident, and often require his or her participation. Rehabilitative programs, such as physical, occupational and speech therapy, and recreational activities of which the list can be but rarely is limitless, are all part of this group.

The Historical Dominance of Physical Care Services in Nursing Homes and Hostels:

Although the need for rehabilitative and recreational activities for the elderly has been well established, these needs are often ignored. It has been observed that reasons for this neglect lie in the fact that:

> "The use of "nursing home" as a label for institutions that care for the chronically ill and elderly focuses the attention of both providers and receivers of services upon the physical aspects of care. As a consequence, the psychological and social aspects of programming, if offered at all, are usually considered as extra services rather than the vital remaining pieces of the total therapeutic milieu. However, effective care cannot be obtained unless all three aspects of life are a part of the total care package." [24]

The Objectives of Psycho-Social Programs and Activities:

In their handbook, Co-ordinated Activity Programs for the Aged, Incani, Seward and Sigler have identified a series of objectives for psycho-social programs and activities in facilities for the elderly. These are:

1. "Develop self-confidence and wholesome life attitudes.
2. Stimulate and encourage social interaction.
3. Encourage self-motivation.
4. Enable the resident to be useful, serving, and loving.
5. Afford health maintenance and rehabilitation.
6. Develop interests and skills.
7. Provide for spiritual satisfaction.
8. Provide intellectual stimulation.
9. Stimulate creativity and expression.
10. Develop substitutes or outlets for continuation of occupation or vocational abilities." 25

These objectives, they believe, revolve around the "primary purpose" of activity programs which is to "pull residents out of withdrawl or seclusion and to remotivate them to function in the normal routines of living." 26

In the same theme, the American classic sourcebook, Working With Older People, has observed:

> "Retirement suddenly presents a great amount of leisure. That leisure which was once merely a period of refreshment now becomes an end in itself. The recognition, status, prestige, self-expression and friendship once afforded by work is now being derived from leisure." 27

Only sensitively designed programs and activities can hope to offset the psychological and social losses that occur when an individual retires from both his occupation and from previous social roles. Martin S. Margulies, who has written extensively on the subject, notes that:

> "The problem of removing emotional blocks preventing successful participation then becomes the major task of the activities leader. Withdrawn or hostile institutionalized aged need to be convinced that their efforts at participation in activities will not end in failure and frustration but rather in success and with a sense of accomplishment. They need to learn through a series of interpersonal transactions that their attempts at social communication and social or creative participation will not reward them only with rejection and humiliation but rather with acceptance, warm human relationships, and recognition of their achievements." 28

In addition to theoretical arguments, there is considerable practical evidence in favour of a continuous program of psycho-social activities. Phyllis Foster, activities consultant with the Colorado Health Care Association, has observed:

> "Parties, movies, dancing, checkers, all these activities provide the person who lives in a nursing home with an opportunity to make friends. This in turn helps to increase his self-confidence, and keep him mentally and also physically active." [29]

Description and Classification of Psycho-Social Activities:

The Activities Supervisor's Guide lists six general types of activities that can be used in working with elderly people. These are:

1. social
2. diversional
3. work
4. volunteer service
5. intellectual
6. spiritual and religious. [30]

In practice these categories may encompass many activities. Incanci, Seward and Sigler list activities possible in a nursing home setting, as:

> "Arts and crafts; audiovisual presentations; cooking and baking; current events and citizenship themes; dance; discussion groups, debates, and symposiums; drama; educational classes; entertainment; exercise; exhibits; games; hobbies; lectures and demonstrations; literature; music; nature and outdoor activities; outings and trips; parties; service projects; special events; sports; visitation programs; and worship services and religious observances." [31]

This list could be expanded with a list of activities that volunteer groups can bring to the institution.

Data in Favour of Rehabilitative Programs and Activities:

As the preceding lists illustrate, it would be possible to name many activities that could be implemented in facilities for the aged. In the traditional concept of "activities" as an arts and crafts area, it is possible to name an enormous variety of pastimes and hobbies that might be pursued by elderly people. Knitting, basket-weaving, copper-tooling, stamp collecting, and ceramics are all activities that come to mind, and are in fact associated in the popular mind with the therapeutic treatment of any institutionalized population. But compiling these lists does little to approach the problem of what types of activities are most beneficial to the institutionalized elderly person, or to suggest what programs represent the trends of the future. Recent practice has shown for example that greater emphasis in the future might be placed on rehabilitative and restorative programs, in addition to recreational activities.

It has been proven that activities that have interested an individual through the course of his life are more likely to sustain his interest and enthusiasm when he is older than activities that he has never previously considered. The best Canadian study on the elderly to date, Aging in Manitoba, has noted that older people report enjoying activities most that had previously been an important part of their lives:

> "Both for the general population elderly and the facility elderly, visiting relatives, visiting friends, using the radio or television, reading or writing, doing light housework or gardening, walking, shopping or driving, and handwork hobbies are the seven activities considered to be the most important activities. " [32]

It is interesting that this list contains few of the arts and crafts or group recreational activities often sponsored by institutions, and even the term "handwork" implies a more traditional and utilitarian approach than that generally encouraged by current craft programs.

In truth, the supposed apathy and lack of creativity complained about by many activity directors has identifiable roots:

> "The answer seems to be that the aged in our society generally do not express themselves by artistic means - largely because the aged are but one part of a general population that does not engage in artistic modes of expression. From colonial times our society has measured progress in terms of production and economic growth. Attitudes, education and mores have been related to this goal of "progress" with relatively little energy directed to the "non-productive" area of art." [33]

It is undoubtedly true that future generations of elderly will have a higher tolerance for leisure, and that they will feel comfortable with the concept of artistic expression, but there is no evidence such people will constitute the majority of the aged until the next century. The evidence is, however, that the "average [American]...lives in a culture that still manifests a distrust and suspicion of leisure; he is imbued with a puritanical faith that life without work is meaningless." [34]

These sentiments only serve to accentuate the retirement crises of role loss, and loss of occupation and income. Incani, Seward and Sigler have noted that for the institutionalized elderly person:

> "Feelings of rejection and uselessness are common, and 'everyone' tells him to relax, rest and let someone else do it... In order that rest might regain some of its physical, psychological, and social value, the nursing home resident must recognize some form of activity related to the 'normal' needs and processes of living." [35]

Activities of this kind can be simply provided by a thoughtful co-ordinator, or can be developed into a sophisticated program of restorative and rehabilitative procedures of the kind discussed under the heading of Occupational Therapy. They are all, however, largely a part of administrative attitude. In her interview for the Ontario Nursing Home News, Mrs. Foster:

> "...told the story of Ann, who at 84, and blind, has the men in the nursing home where she lives bringing their shirts to her for mending and sewing on buttons. Because she is blind the home has provided her with needles with special tops. She is now the chief mender in the home."
>
> "Those who are in nursing homes today belong to a generation of people to whom work good and play a sin, Mrs. Foster said. It's very hard for an 85-year-old woman, who has cared for her house all her life, to come to a home and be told that she can't even make her own bed anymore."
>
> "Ironing, watering plants, dusting, peeling potatoes even, these are all activities the old people should be encouraged to do." [36]

Occupational Therapy:

There is some reluctance to discuss the restorative approach to programs under the occupational therapy heading, as occupational therapy implies a more narrow range of activities than the total care approach that rehabilitative and restorative programming really means. It will be included here, however, because restorative programs are in the occupational therapy tradition, and because they essentially share the same philosophy.

It is obvious that by providing the resident with the opportunity to pursue interests and activities that have concerned him throughout his life, an element of continuity may be introduced into his experience that is frequently lost among institutionalized elderly people. Less obvious, but equally striking is the fact that the continuation of these activities will also help him to retain his life-skill abilities and help him to combat those aspects of "senility" associated with apathy and alienation.

Merely leaving the elderly person alone to manage the best he can will not, of course, accomplish these goals. Rather this is a program that must be actively pursued through a series of structured and continuous programs that are often referred to in the institution as "life-skills retraining" or "reality orientation". The existence of these programs is vital. Martin Margulies has stated that:

> "Any activities program, whether designed for rehabilitative purposes or merely to help the older person sustain an identity, will not be effective unless it directly comes to grips with the aged person's psychological reaction to physical disability chronic illness, reduced social status, dwindled object relations, and constricted emotional discharge.
>
> Unless interrupted, the normal developmental process of aging transforms, with the advent of trauma, into an ever-deepening downward spiral of ego loss--withdrawal--regression--depression--further ego loss--further withdrawal--further regression--deeper depression--greater ego loss and so on until it ends, sooner or later, in senile psychosis. The only possible interruptions of this spiral are death or the conscious sustained intervention of an active agency, a sympathetic human being, skilled intuitively or by training and experienced to break the chain. Even total recovery from the initial trauma, in and of itself, is insufficient to reverse the downward trend once it takes hold." [37]

Astute programs and activities can provide the "active agency."

Specifically these programs can include activities of the following main categories:

1. Prevention and Health Maintenance.
2. Remediation.
3. Daily Life Tasks and Vocational Adjustment. [38]

1. Prevention and Health Maintenance Program:

According to the Guidelines on Occupational Therapy in Nursing Homes and Related Facilities laid down by the Wisconsin Occupational Therapy Association:

> "Treatment in Prevention and Health Maintenance focuses on the assets of a person, not his limitations; therefore, every resident of a nursing home who has been removed from his normal environment, relationships and activities is a potentional candidate for such a supportive treatment program. Since prevention and health maintenance requires an all-encompassing approach, the occupational therapist must consider the total institutional living environment and incorporate all the daily experiences and life tasks of the resident into such a program. Each individual should be provided with meaningful activity to fulfill normal health needs in psychological, social and physical areas."

In practice, this can be accomplished by the careful training of all staff to encourage:

> "...the resident to use self-care skills to function independently in daily life activities, such as utilizing adaptive eating or dressing equipment which the therapist has procured and taught the resident to use. The therapist can also encourage the use of specific approaches and routines as in the management of the confused, disoriented or acting out resident." [39]

According to this model, the therapist may assign residents with specific responsibilities that exercise their participation in the activities of daily living: dressing, bed-making, and light housekeeping. The Guidelines also suggest that:

> "A resident council would be another way of focusing on the assets of the residents. It encourages residents to react to and influence their environment through appropriately structured administrative channels. The resident council can be used as a vehicle for planning activity programs and as a basis for many purposeful daily living activities." [40]

2. Remedial Program:

The purpose of a remedial program is to:

> "...focus on the reduction of pathology or specific disability, providing task and activity experiences which may diminish the particular impairment, restore or develop the individual's capacity to function. In this context the tasks or activities selected will be those whose characteristics and properties will, for example, provide specific exercise and motor learning, offer appropriate sensory stimuli and improve response; promote muscle strength, endurance and coordination; alter disorders in thinking and/or feeling; teach and enhance interpersonal skills; offer the necessary psychological need gratification; correct faulty self-concepts and identity; develop those attitudes and skills basic to the pursuit of independent functioning." [41]

Within any institution for the aged remedial programs focus on specific dysfunctions. Treatment generally approaches problems in any of the following functional areas:

> "Motor, sensory integrative, cognitive, psychological or social performance components of behavior, the prerequisites for adequate occupational performance in self-care, work and play/leisure activities." [42]

Programs may include adaptive programs in life-skills areas, provision and training for the use of orthoses and prostheses, concentration on such cognitive skills as problem-solving and reality orientation and on social and interpersonal abilities.

3. Daily Life Tasks and Vocational Adjustment Program:

This program has been defined as:

> "Daily life tasks and vocational adjustment programs... are primarily concerned with work adaption and role adjustment and where the tasks chosen are those which will enhance the ability to work and/or fulfill age-specific life tasks and roles. This focus involves the identification and examination of those roles and skills essential for the individual's adaption to his community; assessment of the nature and level of his work capacities, attitudes and self-care skills; identification of what learning needs to occur and in what sequence; provision of graded task experiences which will teach the necessary skills and attitudes." [43]

For the institutionalized elderly person with little hope of discharge his skills have, in the past, usually been incorporated into the tasks of daily living. Concentration on his work related skills has usually been reserved for the resident who is expected to return to the community. Recent innovations have changed this outlook. The introduction of sheltered workshops, highly successful in day-care programs but also introduced to include residents, in which participants are paid for their labours, either by the sale of goods or in the form of a small wage, have proven to be satisfactory adjuncts. Whenever possible facilities for programs of this kind should be considered. As Carp has noted:

> "Individuals who worked for pay were happier, had higher self-esteem, better relations with other people, and tended to complain less of having too much free time than did either the volunteers or those who were not in any employment." [44]

It should be observed that the characteristics Carp noted, happiness, self-esteem, and better relations with other people, are the objectives of any determined program for elderly people.

Equipment and Facilities for an Occupational or Restorative Therapy Program:

In terms of facilities the best source states that:

"1. In an extended care facility of 100 beds or more where vocational rehabilitation is part of the rehabilitation program and where special mechanical equipment is required for job retraining, the Occupational Therapy Department should be located in a distinct physical area.

2. For the retraining of handicapped housewives, an equipped kitchen should be included in the physical facilities.

3. For an institution of 100 beds or less where vocational rehabilitation is not a realistic goal for the 20 or fewer patient candidates for functional occupational therapy, occupational therapy should be offered in:

   a. Recreation, community, and dining areas
   b. Patient bedrooms and lavatories.

4. Notwithstanding the size of the facility, diversional and recreational occupational therapy should take place in general recreational and community areas to encourage the socialization of patients and their adaptation to the social milieu." 45

In terms of equipment, it lists:

"1. Arts and Crafts Materials. The maintenance, storage, and purchasing of arts and crafts supplies and equipment should be the responsibility of the occupational therapist in consultation with the director of recreation, and the basic equipment should include a kiln and various types of looms.

2. Special Equipment. Self-help devices should be available in the extended care facility for the "activities for daily living" program." 46

Physical Therapy:

Resources to be allocated to a physical therapy program depend upon the size and resident profile of the individual facility. In larger settings, separate areas should be designated, and programs maintained utilizing some or all of the following equipment:

Whirlpool bath	Parallel bars
Infrared lamp	Sand bags
Diathermy machine	Door pulley
Hot packs and Hydrocollator	Wheelchairs
Standing or tilt table	Walkerettes, canes, crutches
Stall bars	Traction apparatus
Shoulder wheel	Trapeze frames

In a facility requiring physical therapy programs for 25 or fewer persons, existing areas offering "shared privacy" can be utilized such as treatment or examining rooms, community rooms, patient bedrooms and bathing areas. Wherever possible physical therapy programs should be related to the occupational therapy programs, and in the smaller facility space might be shared.

In this vein, it might be noted that existing circumstances prove the importance of adequate programs as well as facilities:

> " Idle equipment, gathering dust while the patients go without its benefits, gives all too accurate an indication of what is happening in most nursing homes. Even when the home had a physical therapist on the payroll, he often was little used because, as several therapists told us, the aides would not bother to bring the patients to them. We heard the same complaint from activities directors: the patients were not brought to them." [47]

A restorative therapy orientation, aimed at maintaining and enhancing life skills, reinforces the need for physical therapy programs and encourages participation. Whatever the size of the facility, physical therapy equipment such as "parallel bars (and possibly shoulder wheels and stall bars) should be located in a general recreation and community area to encourage more frequent practice by patients between treatments, assisted by nursing staff." [48] In addition, the following aids to mobility should be available administered by the physical therapist:

Wheelchairs
Walkers
Crutches
Canes
Bedrails
Trapeze frames.

Speech Therapy:

Equipment and facilities required in speech therapy programs may include:

a tape recorder
a record player
a slide projector
printed cardboard visual aids.

Speech therapy should be conducted in a private soundproofed room with a sufficient number of chairs for group as well as individual therapy. [49]

The Current Situation:

There are many facilities for older persons operating in Canada which are oriented toward residential, therapeutic environments. They attempt to provide opportunities for recreation and activity in the interests of their residents, in settings intended to minimize the institutional "hospital" atmosphere and emphasize abilities of residents rather than their limitations.

Unfortunately, these are a minority, and the greatest number of Homes for the Elderly in the country provide little more than the minimum needs of shelter and medical care. In a study of facilities for older persons conducted in Manitoba, for example, results showed that over 81% devoted little or no time to entertainment and recreational activities, to outings, and to physical exercise or hobby programs. [50] Although most facilities do employ a craft worker, few have recreational directors to initiate activities. And, as discussed earlier in this paper, residents find craft work rewarding when it is a continuation of their interests in earlier life, and much less so when it is an entirely new experience.

Many studies* indicate that the elderly in long-term care facilities spend the greater part of the day doing nothing or engaged in passive activities, rocking, watching television, or just sitting.

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* Including one conducted by this office.

Very little time is spent in social contact or organized home activities. Contact with staff is minimal. Activity programs are often highly structured and directly related to some form of therapy or rehabilitation. Though residents express the desire to leave the facility more often than they actually do, organized outings are among the major events of the year.

Meeting User Requirements in the Future:

Traditionally, such facilities have been oriented toward custodial care, and the change to providing modified residential settings for the continuation of meaningful, active lifestyles for the aging is slow in coming.

The primary factors to be considered in developing sound concepts for extended care residences are the needs which these facilities are intended to meet. Now and for the future, they involve more than the customary food, shelter and medical support. Here is a possible list of basic resident needs:

- shelter
- food and clothing
- household maintenance
- health: physical functioning
- health: self-maintenance (bathing and toiletting)
- health: mental functioning
- psycho-social needs (includes personal relationships, sense of self)
- economic resources
- access to community resources

The degree to which these needs are addressed will differ between nursing homes and hostels according to the nature of the institution and the needs and capabilities of residents. Encouraging residents to participate in the self-fulfillment of these needs, as one does in an ordinary active life, is a key notion in the development of a supportive rather than custodial role for extended care residences.

The User's Perspective:

Successful buildings are those which suit the characteristics and requirements of their users. This match is especially critical in a care facility for the aging. There are often few alternatives, and always the possibility that the rest of the residents' life will be spent in this setting. As the aging in our society become educated in the possibilities of life after retirement and after the need for extended care, the expectations brought to a home for the elderly become more complex. Naturally, people will expect to continue their previous lifestyle and continue to engage in the types of activities they have always pursued. Programs and facilities developed for elderly people should provide for these activities. For example, it is unreasonable to expect that a woman still capable of doing so should give up polishing cherished pieces of furniture or tending a garden, simply because she has had to move into a care home.

A sample of activities people expect to continue might include:

Active Hobbies

fishing, exercise, hunting, athletics
gardening
driving
visiting relatives and friends
handcrafts
walking
shopping
doing light housework
doing odd jobs
cooking
raising animals
photography
club work
attending cultural events

Sedentary Hobbies

reading
sewing
radio listening
television viewing
spectator sports
card games
conversation
writing
collecting
music
crossword puzzles
painting
sitting on porches
observing

Many aspects of residents' previous lifestyles could be incorporated into the institutional setting if modifications were made to allow for losses in physical functioning. Rather than planning highly structured exercise or recreation programs, recreation and therapy staff should focus on developing the residents' personal interests into beneficial activities. Gardening plots or window boxes to grow and sell flowers and provide points of interest on a stroll, music or dance clubs, theatre clubs, a group making home preserves or fixing bicycles, any activity which provides an element of continuity will help the aging person maintain a sense of self.

In some cases these possibilities influence the design of the facility, as in creating sheltered workshops, but often the required change or adaptation is in administrative policies.

Trends for the Future:

If programs are to be developed which meet the psychological and social needs of aging residents, emphasis must be placed on the maintenance and support of basic life skills. While the "make work" programs and hours spent in passive activity which are the present norm in institutions for the aging are not in themselves undesirable, opportunities for other forms of activity which fulfill the desire for interest and involvement must be made available. Long-term facilities need not be "closed" institutions, and can be integrated into certain aspects of the life of the surrounding community. The physical setting can be designed to provide a residential atmosphere which blends into the community and invites the participation of non-residents. A day care program for aging persons still living in the community and a senior citizens centre will create a flow of activity between the two, as will a medical service operated on a clinic basis. Handcrafts and sheltered workshops with contemporary products can create a limited amount of commerce, and residents can provide services for the community in charity work.

The present aging population is one for which leisure has been limited in value, and the rewards of work are self-fulfillment, acceptance, achievement and self-worth. Future aging populations more at ease with the concept of leisure will be better able to find personal rewards in creative activity. Consequently, the types of meaningful activities to be provided by the institution will change.

A restorative therapy orientation is aimed at maintaining life skills through a continuation of activities pursued in previous life. The work/leisure definition is de-emphasized, and the focus is placed on maintaining the individual's physical and mental capabilities, whether through playing bingo or cooking his or her own breakfast.

In designing and planning for the future, it is necessary to incorporate sufficient flexibility, to meet changing needs, in both concepts: the provision of functional space and the delivery of programs and services.

Design Implications:

Design guidelines are generally based on philosophies of care. A medically-oriented approach will produce facilities different in nature from those committed to a supportive environment approach maximizing resident independence. The types of programs and services to be delivered should be anticipated and often well defined before the design stages, in order that provision is made for appropriate space.

Nonetheless, the delivery and effectiveness of programs and services are largely a matter of administration and management. With foresight in planning, many spaces can be easily adapted to meet changing needs and uses. The keynote is spaces designed on sound principles of user requirements, with an emphasis on flexibility.

Physical Space: *

The residents of hostels and of nursing homes in particular depend to a large extent on their environment for support in terms of social feedback and mental functioning as well as physical care. More emphasis is thus placed on the immediate living environment to provide the fulfillment of individual needs. These criteria impose specific conditions on the concepts of design and management of the facility which are limited only by our own level of information regarding the elderly and their needs and by the possibilities of space, economy, and organization.

As Incani et al put it:

> "An activity program requires space to operate. The lack of any obviously available space has, unfortunately, kept many nursing home administrators from seriously considering the establishment of an activity program." [51]

Exterior:

On the grounds, landscaping can create space for gardening, attractive setting and strolling areas and open spaces for gatherings and outdoor games such as shuffleboard, adequately protected from the weather.

Interior:

The layout should include specific areas for physical therapy and occupational therapy and several multi-purpose recreation and activity areas. A large multi-purpose hall can be converted to smaller spaces by means of sliding partitions. Accessory spaces for lockers, washrooms, storage rooms, etc. should be located close to related activiity areas and accessible to residents.

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* This will be covered in greater depth in a later working paper and in the design guidelines.

Adjacencies:

With careful planning, programs and activities can be organized in adjoining areas so that one or two staff members can manage several activities simultaneously. The relationships between areas are determined by usage and their locations based on flow patterns. For example, dining rooms and activity areas should be centrally located for the convenience of all residents. Sitting rooms should be placed near high-activity areas in corridors, as residents also enjoy observing others. The accompanying diagram shows how these relationships can be determined. [52]

▲ Denotes Interaction
(▲) Denotes Significant Interaction

	Nesting	Sleeping	Maling	Rehabilitation	Grooming	Nourishment	Excretion	Storing	Passive Activity	Engaged Activity	Locomotion	Meeting	Working	Competing	Learning	Meditation
1. Patient\Resident Rooms	(▲)	(▲)	▲	(▲)	(▲)	(▲)	(▲)	(▲)	(▲)	(▲)	▲	(▲)	▲	▲	▲	(▲)
2. Lounges		▲		▲		▲	▲		(▲)	▲	▲	(▲)	▲	▲	▲	▲
3. Corridors		▲		(▲)		▲	▲		(▲)	(▲)	(▲)	(▲)		▲	▲	
4. Dining Rooms				▲		(▲)			▲	▲	▲	(▲)		▲	▲	▲
5. Entrance Areas & Lobbies		▲							(▲)	▲	(▲)	(▲)		▲	▲	
6. Activities Areas									▲	▲	▲	▲	(▲)	▲	▲	
7. Bathrooms				▲	(▲)		(▲)	▲		▲					▲	
8. Occupational Therapy Areas				(▲)						(▲)	▲	▲	(▲)	▲	(▲)	
9. Physiotherapy Areas				(▲)						(▲)	▲	▲	▲	▲	(▲)	
10. Beauty Parlors\Barber Shops					▲				(▲)	▲		(▲)				
11. Chapels & Worship Areas																(▲)
12. Outside Areas		▲		▲		▲	▲		(▲)	▲	(▲)	(▲)	▲	▲	▲	▲

Place-behavior interaction matrix. Spivak's (1973) behavioral archetypes can be checked in relation to the spaces that are accessible to patient-residents. In this way the functional characteristics of a space can be more realistically assessed. Interactions shown here have been derived from over five years of experience with observation techniques and clearly show the "multifunctionality" of accessible nursing home spaces.

Accessibility:

To encourage the residents' participation in programmed activities and generally in the life of the home, all areas used by residents should be easily accessible. This includes convenient distances for walking or wheelchair operation and easy horizontal and vertical access. Heavy, narrow doors, long corridors and dim lighting are unnecessary obstacles.

Adequacy for Residents:

Proper ventilation, lighting and temperature control within activity areas is important. Room size and furniture arrangement should allow for mobility and perception problems of older persons, including consideration of optimum visual and conversational distances. Colour and texture can play a large part in the subjective enjoyment of a space, and conversely such barriers as slippery floors and uncomfortable furniture can create negative impressions.

Community Interaction:

When planning activity areas some consideration must be given to programs involving non-residents. It may be that a given facility will want to evolve programs which include a high percentage of senior citizens living in the community, for day-care, clinical services, or a "meals-on-wheels" program. In addition to space requirements, design should ensure that some degree of separation is provided to ensure privacy for on-site residents.

Site:

The facility should be located with convenient access to other medical care facilities, to public transit and public areas such as parks, libraries and shops. It should be convenient to visitors and other members of the community, preferably in a predominantly residential setting. Attempts should be made to provide easy access for residents to other resources in the community.

Staff Implications: *

A clear staffing policy is an important element in planning and should reflect the administrative philosophy of the facility as a whole. A highly structured program of activities may be less desirable than one which is designed to react to the interests of residents, and encourage their participation in the management of activities. The role of staff in this area is as much to provide opportunities for resident independence as to organize specific activities.

Non-support staff should be instructed in the aims of the institution, to emphasize a residential atmosphere and respond to ideas and activities initiated among residents themselves.

It is generally recognized that for moderate to large facilities an activities director or rehabilitation therapist is a necessary addition to the staff, to supplement the craft worker and the physical therapist. In a restorative therapy approach strict boundary lines between recreation and physical therapy are eased, and the beneficial effects of any type of activity which maintains physical and mental functioning are recognized. It is the rehabilitation therapist's task to discover what the individual resident's requirements, capacities and interests are, and how these can be directed toward meaningful activities. It is also essential that the full resources of the facility and its connections with the larger community, be made available for the residents.

The Role of Volunteers:

Volunteers from the community can accomplish a great deal in providing services to residents. Not only recreational activities, but social support services such as "adopt a grandparent" programs can be provided. The volunteer worker generates interest first because he or she establishes a link with the community outside the facility, and secondly

* Staffing is a large and important subject. Although beyond the scope of this study, a few major issues are touched upon here in order to stimulate thinking and discussion. No attempt has been made to address the complex issues of staff to resident ratios, specific training programmes, etc.. We believe that information on these issues will be best obtained by field interview or questionnaires, directed to specific administrative personnel in the various regions of Canada.

because the volunteer has a more casual role than a staff member and can be involved in less structured interactions, such as friendly visiting, letter writing, and simply chatting. Staff rarely have time for "idle" conversation, and yet this is an important outlet for residents who need to express their thoughts and fears.

Staff Training:

An increasing number of long-term care facilities for the elderly are providing some degree of training for staff members, and such training is mainly in the area of psychological and social care. In-service training programs and continuing education programs are thought to have great benefits. [53]

Staff Attitudes:

The importance of staff attitudes cannot be over-emphasized. As Brody (1970) has written:

> "...as important as the services is the manner in which they are given - patience, compassion, kindness and respect with the caring and hope they convey. "
>
> (p. 289)

> "Attitudes of staff have a direct impact: Physical dependency and mental confusion increase when staff have negative, disrespectful or belittling attitudes and conversely, more positive mental conditions are related to permisssive, friendly staff attitudes and positive expectations."
>
> (p. 300)

Baldwin (1977) states that personnel should be trained to treat the patients with respect and as though they were basically well and self-sufficient, rather than always sick with an occasional good day.

FOOTNOTES

WORKING PAPER # 3:
PROGRAMS AND SERVICES IN NURSING HOMES AND HOSTELS

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APPENDIX A

EXAMPLES OF ACTIVITIES PROVIDED IN A NURSING HOME

No single activity or innovation can do the entire job that must be done in long-term care. A total effort is needed on a variety of fronts. One of the most comprehensive efforts to reach the Subcommittee's attention was provided by the Iowa Soldier's Home in Marshalltown, Iowa. There, staff must deal with the needs of domiciliary patients, others requiring skilled nursing, and still others needing more intensive care. In a letter, the administrator gave this list of efforts that might be regarded as "extras" in other facilities:

- Because many of the residents are handicapped and in wheelchairs, the grounds are planned for navigation by them.
- Tables are designed to have wheelchairs fit around them and ramps are provided as an alternative to stairs.
- The grounds feature several birdhouses for birdwatching residents.
- The little league baseball team plays on the grounds in summer.
- The home's grounds is the site of the annual community Easter egg hunt. Residents participate in hiding the eggs.
- Band concerts are held on the grounds through the courtesy of the local musicians union.
- The hills are used for sledding in winter, for parties and picnics in summer.
- Shuffleboard tournaments are held.
- Students working on degrees in nursing work with the residents in both degree and practical nursing programs.
- Reality orientation is practiced with calendar, clocks, and with signs over the patient's beds indicating name, home, and activities for the day.

- A program of government by patients is being tried with suggestion boxes available and meetings arranged between the administrator and the patients.
- There are no restrictions on visits; in fact, children are encouraged - a toy box is provided for their use.
- A rehabilitation kitchen is provided with all appliances adapted for use by the handicapped, including low sinks, radar ovens, and other kitchen aids. The elderly and handicapped can try their hand at preparing their own meals and can even participate in the shopping for these meals - in making lists and going to buy food.
- A library is provided with specially-designed furniture.
- There is a snack kitchen.
- Residents participate in small appliance repairing, wheelchair repair, woodwork, leatherwork, sewing, and quilting.
- A foreign food fair is held with residents dressing in the costumes of the country where their food originated and food is sold by "the taste."
- A fashion show is held with residents participating; likewise, there is a wig show and a hat show.
- Periodically one of the local department stores brings goods and opens a branch in the nursing home for a short while to enable the residents to buy a few needed items.
- Visits are arranged for Miss Iowa and Miss U.S.A..
- Residents prepare Christmas cards to send to families and friends.
- Costume parties are held.
- Bulletin boards commemorate birthdays with photographs of residents as well as charting the daily activities.
- Adult education is provided in painting, secretarial work, dancing, welding, typing, and biblical history.
- The home runs a toy repair service turning restored toys over to the Salvation Army for distribution.
- The home runs a Santa Claus answering service so that young boys and girls can call or write to the home and hear from Santa.

- A supper club activity is held monthly for residents who have little opportunity to eat in restaurants.
- Church services are provided for all denominations.
- The residents choose an employee of the month who receives a $25 savings bond.

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pp. 602-603.

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