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A Method for Meeting Psychosocial Needs of Institutionalized Elderly

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A METHOD
FOR
MEETING PSYCHOSOCIAL NEEDS
OF
INSTITUTIONALIZED ELDERLY

Submitted in Partial
Fulfillment of the
Requirements for the
Degree of Master of
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by
Mary Pardue Abrahams
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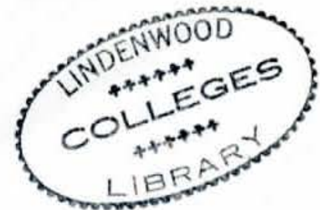

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PREFACE

Personal experience with people who fall into the age group which is most likely to need institutionalized care has shown the need to have long term care facilities made less threatening to the general public. Stereotyped attitudes of relatives, doctors, nursing personnel, and of the elderly themselves must be explored and new approaches developed if the available quality of care is to be improved.

Field experience in a nursing home and case work with the elderly in an outpatient mental health clinic produced much of the material used in this study. The thesis that the quality of institutional care could be greatly improved by the use of an inservice education program for the nursing staff resulted from this field work.

This paper notes and accepts than an inservice educational program must be approved and encouraged by the total staff if a better quality of care is to be the result. However, the nurses' aides who spend 80% of their time in contact with the residents can institute a more intelligent approach to the quality of life provided, if they are educated for the job they are doing.

An extensive research into the literature was conducted in order to determine what efforts had been made to utilize inservice education to improve the quality of care in long term care institutions and to evaluate the results when this approach was used. This research revealed that inservice education is effective in long term care institutions.

A survey of the literature was made to identify the types of individuals employed in a nursing home. This research covered age, educational background, reason for electing to work in a nursing home, and personal interest in geriatrics.

It can be concluded that these employees are interested in improving their knowledge and skills and where inservice had been offered, the quality of care has improved.

Personal interviews conducted during this study with key people in the field and with colleagues have been most informative. Dr. Jeanette Chamberlain, head of the department of long term care facilities in Health, Education and Welfare and Ms. Eleanor Friedenberg, Chief, Provider Improvement Branch in Public Health Services gave generously of their time and expertise. They guided me through the masses of literature pertaining to the personnel of long term care institutions enabling me to locate that which was pertinent to my interest. Both gave constructive criticism concerning my project and helped direct a systematic approach to the research.

Ms. Stephanie Joyce, head, Department of Gerontology at the Woodburn Mental Health Center in Northern Virginia has been available for suggestions, criticisms and general useful information. She has opened doors for me so that I received assistance and information from the Fairfax County Department of Resources when it was needed.

As more research was compiled, the idea that reaching for a more satisfying quality of life for institutionalized people through the education of nurses' aides was strengthened. A decision was made to provide a plan of inservice education which would be concerned with the psycho-social needs of the residents and greater job satisfaction for the employees.

Much of the material has been taken from personal experience. Suggestions for evaluation of the teaching and of the results achieved with the residents have been included with other instructions for the teaching staff. Some sample evaluation tests are provided. However, it is more useful if the case histories and other illustrative materials presented in the classroom can be taken from the experiences on the job which are occuring simultaneously.

The scope shall be limited to a series of eight class plans with guides

for the instructors, lists of materials needed, a pre-test, evaluation tests for both the instructor and the student, a list of available audio-visual aids, a glossary of terms, and a bibliography.

Research stresses the need for full administrative approval and support. This support is necessary to insure that the teaching provided in an environment which has room for free outlook and liberty of action.

INTRODUCTION

The attitudes held by our youth-oriented society towards the aging individual deny both the young and the old the full joy of living. If we react to aging as a total, degenerative process, we would only see the losses, the impairments, and the dependent part of some chronic illnesses. This would prevent us from satisfying the most urgent and vital need of the elderly--the need to be accepted as a total person.

It is difficult for us to allow the nursing home resident to express emotion. We feel too helpless, too involved and too threatened. None of us can really accept the possibility that we may end up in this type of a situation and in the presence of severe despair, we wish to escape and this often results in a rejection of the person we are trying to help. We turn from the person who cries all the time, or who is completely occupied with their elimination processes. As a result, the most needy individual receives the least help. It is important to recognize other channels for a more appropriate and acceptable outlet for some of this emotional conflict.

Fears of growing older and dying arouse many levels of anxiety in those of us who work with the elderly. It is imperative that we examine our own feelings and develop techniques of relating to patients so that we will not communicate our own fears and further complicate their own anxieties. Understanding the aging processes is basic if one is to help patients deal with their fears of being very lonely; their physical limitations; and fear of death. This knowledge and understanding of aging and of ourselves is necessary if we are to assist the aging population toward a continuing, active participation in life.

The older person's desperate need for human contact often illicits irritability in the staff who are not aware of these needs. It is not possible or prudent to deal with residents in a nursing home as one would care for patients in a general hospital. Hospital care is based on treatment which will, in a relatively short time, restore complete health. The nursing care in a hospital is usually concerned with one specific illness or accident. The nursing home resident will probably have several disabilities which may not be curable. Many will continue to deteriorate rapidly. Since the resident may only be discharged by death, a living care program rather than a nursing care plan is needed. The focus of care in a nursing home is identifying how the residents wish to live the life they have left and helping them to live it.

Residents of nursing homes must consider their allotted space 'home'. As each one attempts to mold their individuality to the structured environment of the institution a variety of problems arise. If the nursing personnel is not cognizant of the difficulties involved when an elderly person is faced with this adjustment, the needs of the residents may be experienced as burdens which upset the routine procedures of the nursing home.

Residents who exhibit psychosis or hallucinations are understood by medically trained people to be suffering from an illness. As a result any irresponsible behavior the staff observes in people with these diagnoses is appropriate to the illness. The mute, withdrawn, or overly demanding individual may be considered uncooperative and stubborn. The staff may see them as hostile individuals who are deliberately trying to be difficult. Often staff members will react in a like manner and more confusion is created for both the resident and the staff. Knowledge of the aging process; the adjustment necessary to life in an institution; and a respect for the

richness of the human experiences which the elderly bring with them is necessary for all staff members if favorable psychological atitudes toward the residents are to be established.

The nursing home facility and method of operation have closely followed the traditional hospital system. Procedures and schedules have been given primary importance. Hospital staffs have been taught to maintain a professional attitude which limits the relationship with patients to a formal and distant one. Patients in hospitals with an acute illness which will be of short duration may be able to improve rapidly without personal involvement, but the nursing home resident plan to spend the rest of his/her life there and needs to interact with the staff.

The nursing staff must be encouraged to be more concerned with the person behind the physical body. They must have the freedom to neglect routines if the residents are engaged in some productive or enjoyable activity. In order to exercise this freedom with wisdom, the nursing staff must be aware of the psycho-social needs of the residents and possess skills and knowledge which will enable them to effectively achieve a high quality of care.

For the past five years, I, as a registered nurse, have spent a great deal of time with elderly people who are confined either by physical, mental, or emotional problems in institutions. I have observed the attitudes of society, professionals, paraprofessionals, and their families toward these older citizens. I have become greatly frustrated by the poor quality of life that is promised if one should be unfortunate enough to need institutionalized care.

My research of the care the elderly receive in nursing homes shows that most of the personal contact was provided by nurses' aides. These employees have had little formal education. Training for the job before employment does not exist and most nurses' aides have had no previous job experience. The

work is physically demanding and often unpleasant. The salary is low with little opportunity for advancement.

With the above working conditions, the employer expects the aides to provide all personal physical care necessary to the residents and to deal with the psycho-social needs of the residents as well. No education in geriatrics, gerontology, or problems of the aged is provided. Nevertheless, most of them do their work with gentleness and compassion. Their problem in dealing with the elderly comes from a lack of knowledge, and a lack of useful techniques which they may use to cope with behavior problems. Lack of an opportunity for advancement creates personal dissatisfaction with the job and may account for the high turnover rate of these employees.

Research studies have shown that most aides have a desire to improve the quality of life offered to the institutionalized elderly. The most potent force for quality care is found in the compassion of the person giving the care. Roles in the structure must be clearly defined. Recognition and acceptance as an important member of the nursing staff is vital.

Why assume that the nursing staff personnel will respond favorably to an inservice teaching program, that those with negative attitudes toward the aged will accept and utilize new information? A review of the literature has shown that progress has been made when inservice education was provided in a systematic and practical manner. The projects which were not successful generally lacked the interest and cooperation of the administrative staff. This resulted in the teaching staff finding difficulty in securing a convenient time and place to have classes, source materials were not available, and employees were not allowed time off to attend the classes.

The administrative staff often have not had sufficient education in the field. They may feel threatened if the employees are given specific educational skills. They may fear losing their authority if all levels of personnel are participating in open discussion. They may fear the cost of

the education and of changes which newly educated employees may demand. Recently, states are requiring administrators to become involved in continuing education courses for themselves. These courses could sensitize the administrators to the need for psychosocial awareness in their institutions.

The media has given the lack of quality care so much space that the general public, the residents, and the working staff are all pressuring for improvement. If the key people of the institution show enough concern for the needs of the personnel to establish a time, a place, and professional educators to supply the necessary knowledge, the employees will certainly gain not only in ability to solve the problems of the residents but in their own self esteem. This will ultimately raise the quality of patient care.

It is necessary to emphasize the psychological (mental health) needs of the institutionalized elderly in order to help compensate for the many and varied losses aging may produce. This does not minimize the necessary and important provision of physical and medical care.

It is possible to provide a nursing staff with the ability to supply task-oriented care and also supply care which would improve the life and functioning of the residents. To do so requires an understanding of the aging process, an examination of the myths and stereotypes which are held by our society, and a re-evaluation of the rights of the resident.

The elderly residents must be provided with the opportunity to:

1. give and receive love and affection
2. develop new relationships
3. have social contacts
4. be given a choice in as many activities as they can manage
5. be freed from the fear of lonliness
6. be helped with rehabilitation services if needed

Ultimately the resident must be helped to face death.

An inservice education program can be very simple and direct. The

personnel can be encouraged to decide what they need to learn and to offer solutions to the problems as they see them. The subjects can be adapted to the needs of the staff and their on-the-job problems. Skills can be taught which will provide immediate rewards for the student, the teacher, and, most importantly, for the resident of the nursing home.

Inservice education is essential for quality care. Formal pre-job preparation can not replace on-the-job training in nursing homes. As a former clinical instructor of student nurses, I am well aware of the tremendous boost the practical application of theory gives to proficiency on the job. It is the most meaningful method of educating nurses' aides.

A handbook with detailed lesson plans and teaching instructions for eight classes has been designed. A list of materials needed; a pre-test; self evaluation tests; a list of audio-visual aids; a group of handouts, a glossary of terms; and a bibliography are presented.

It is suggested that this handbook be used as a basic group of lesson plans. The nature of the institution and the educational background of the personnel will dictate the choice of many of the classes. It is essential that plans, programs and schedules be maintained. Effective education can not be produced in a random way. The instructor should, however, be flexible and be particularly sensitive to the reactions of the students. Problems that need to be solved in the job situation may need to take precedence on occasion. The students should be encouraged to present case histories which illustrate difficult problems. Expression of emotional frustration to on-the-job situations will create excellent topics for classroom discussion if guided into constructive channels of communication.

Attitudes are learned and therefore can be changed or modified. Education can produce a more positive approach to the care of the elderly. Personnel can be shown the challenge of working with the aged. Interest can

be stimulated. They can learn to value the job as one that is contributing in an area where they are needed and appreciated. Inservice education is the most efficient, the least expensive, and the most available method for creating a happier environment.

NURSING HOMES

The long-term care institutions of today have become highly complex organizations which attempt to provide total care to the completely physically helpless individual; to the mentally disturbed individual; to the chronically ill or disabled individual; and to the individual who needs varying degrees of help in order to overcome an acute illness or accident. These institutions also attempt to provide a 'home life' atmosphere for their residents and it is this goal that has proven the most difficult to achieve.

A study by Eva Kahan of the humane treatment of the residents in long - term care institutions found that the facilities are frequently more interested in outward appearances than in inner realities. The study also reports that social conscience is aroused by signs of poor maintenance or limited supplies, but is insensitive to an atmosphere of hopelessness. This study concluded:

> Often inattention to human needs is caused by consideration of economy. Nursing home staffs are often poorly paid with resultant high staff turnover. Inexperienced and unqualified staff then contribute to a routinization and a dehumanizing environment in which people are treated in batches, are crowded, and are isolated from meaningful social contacts.[1]

Long-term care facilities are based on a medical model which means that physically and administratively, they operate in the same manner as a general hospital. The planning of space in such a facility does not consider the resident's needs for privacy; for self; or personal belongings. Too, the efficiency of the staff is determined by a scheduled series of routine procedures. This concentration on a time schedule administered to all in a like manner does not provide the opportunity to produce a satisfying quality of life. The lack of concern for the human dignity of the residents is

expressed by the administrative methods which accent order, system, and schedule as the most important functions of the facility.

The Public Health Service reports a very dismal picture of life in a nursing home:

> There will be routine procedures to keep him from accumulating possessions which could have meaning to him. There will be no safe place to keep things of value (no more than the derelict who sleeps with his shoes tied around his neck) so he will be unable to keep them or will have to leave them, as money, in the distant safe. What he has will be periodically searched and examined. He will have to 'get permission' from those to whom his responsibility has been given, to do what he ordinarily did spontaneously before. Nothing will be required or expected of him. His routinized life will be offered to him. All that is required of him is compliance, without objection, choice or complaint.
>
> His major task will be to unlearn his former way of life; to separate himself from all that has had meaning for him; to tolerate frustration of expression and action, a distance from people, a violation of total privacy and of life long values; and to exist in a patterened monotony of time. He will soon attain full 'object' status, attested to by the name band he already wears on his wrist. He will be fully 'adjusted' when he becomes totally disinvolved; emotionally flat, without motivation and mentally removed.[2]

It is difficult for medically trained personnel to relax and let schedules get by passed. To accept that clutter in a room is the essence of the resident's belongings; to tidy the room is an invasion of privacy.

Personal needs become paramount to the chronically ill person. The lack of motivation on the part of the geriatric person is a major problem for the nursing home staff. It is often easier and certainly quicker to 'care for' rather than 'care about' the residents.

In recent years, nursing homes have been given severe criticism by the general public for failing to satisfy the emotional and social needs of the residents. As a result, the development and maintenance of inservice education activities which will improve patient care and service have become an important function of the nursing home.

Nursing Home Facilities

Three categories of nursing homes have been established by the federal government[3] according to the level of care provided:

1. Skilled Nursing Facility
2. Intermediate Care Facility
3. Domiciliary Care Facility

A Skilled Nursing Facility provides comprehensive nursing care and services under the direction of a physician, and under the supervision and observation of a professional registered nurse on a continuous basis.[4]

Generally, a minimum of 2.25 hours of nursing care per patient per day is required. Skilled nursing procedures include such services as oxygen therapy, skilled rehabilitation, tube feeding, and administration of intravenous fluids and medications.[5]

Some nursing homes are also extended care facilities providing skilled nursing care under the medicare program.

An Intermediate Care Facility offers only basic medical and personal care procedures, such as surgical dressings, injections, administration of medication, and assistance with dressing, eating, and bathing. A person can be bedfast and require assistance in activities of daily living and may still be eligible for intermediate care. An intermediate care facility is required to have professional personnel.[6]

Domiciliary Care Facilities focus on providing non-medical services to persons who, because of age or disability, cannot function in independent living arrangements. Domiciliary care consists of help with personal needs, assistance in performing housekeeping chores, administering medications, supervision in carrying out the basic activities of daily living. Government regulations do not require licensed nursing for domiciliary care facilities.[7]

There are basicially two types of nursing homes, private profitmaking and non-profit. Non-profit institutions are sponsored by various groups or operated by public agencies. Private homes are operated for profit by individuals or corporations and may be part of a chain.

Each nursing home has a governing body and meetings are held periodically to set policies, adopt rules, and enforce regulations which provide for the health care and safety of patients.

Each nursing home is required by the licensing regulations to have an administrator who is in charge of the daily management of the nursing home. This person is to be licensed by the State Department of Professional and Occupational Regulations.

Nursing homes are required to meet standards set by state and local laws and regulations, and must have a state licience by the State Department of Health to operate. Nursing homes that are certified for participation in Medicare and Medicaid are required to meet standards set by federal and state regulations.

Nursing Home Personnel

Standards are determined by general government regulations which are too vague for practical use such as:

> Nursing personnel, including at least one registered nurse on the day tour of duty five days a week, licensed practical (vocational) nurses, nurse aides, orderlies, and ward clerks, are assigned duties consistent with their education and experience, and based on the characteristics of the patient load and the kinds of nursing skills needed to provide care to the patients.[8]

Registered and practical nurses are defined as "...nurses licensed by the State in which practicing."[9]

"...rehabilitative nursing care: nursing personnel are trained in rehabilitative nursing care which is an integral part of nursing service and is directed to achieved and maintain optimal level of self - care

and independence. Rehabilitative nursing care services are performed daily for those patients who require such service, and are recorded routinely."[10]

Nursing homes are required to have a physician on their staff at least part time to serve as medical director. It is the responsibility of the medical director to coordinate all medical services, although he may not provide direct patient care.

In addition to the regular staff - registered nurses, licensed practical nurses, nurses' aides, and orderlies - most nursing homes have specialists come into the home on a regular basis to provide checkups of patient's teeth, eyes and feet.

Other members of the nursing home staff usually include a social worker, dietition, therapists, and an activity director. Volunteers are often used to assist the staff with patient activities.

All nursing homes are required by law to develop a plan of restorative care when a patient is admitted, and to review each patient's plan of care periodically to insure appropriate care.

Most nursing homes offer three types of therapy:

1. Physical therapy which involves the use of exercises, massages, and special equipment to help patients improve their abilities to perform daily living activities.

2. Occupational therapy which is used to develop skills by involving patients in craft activities.

3. Speech therapy which helps patients overcome speech and language difficulties such as those due to a stroke, hearing loss, or neuromuscular disorders.

The social work staff deals with the emotional and social needs of the nursing home patient.

A program of recreational activities supervised by a qualified

coordinator may include individual or group activities. Some nursing homes have a "Patient's Council" which helps plan and carry out the activity program.

Most nursing homes provide opportunities to attend religious services and to talk with clergy, whether in the home or in the community. Some homes have a chapel which is always open for private meditations.

Nursing homes generally provide the basic essential services in a like manner. The deficiencies in the care of the residents are mainly in the failure of the institution to meet the psychosocial needs of the inhabitants. It is very difficult to define and teach rebulous concepts such as love, caring, compassion, and empathy. To implement the type of care which would provide satisfaction of these needs requires not only a more sensitive, better educated nursing staff, but more freedom from task oriented duties.

After a resident needs to have someone who can sit and listen, someone who does not need to rush away immediately, someone who not only hears but is able to comprehend what is being said. Active nursing home residents have a right to some of the staff's time in order to stay active and alert. Geriatric patients often kick up a fuss, in order to get someone to pay attention to them; to be scolded is better than no attention at all.

The quality of care must go beyond meeting the essentials of daily living. The staff must now be concerned with helping the residents find and live the best life style that is possible for each individual. In order to meet these demands, the staff must be educated to the emotional and social needs of the residents.

The Nursing Home Family

The residents of a nursing home are there either because they chose to live in an institution or they were placed there by their physicians or families. Whether the admission to the facility was voluntary or involuntary, very few residents consider the institution as a home. Life in the institution is seen as 'existing' not 'living' and frequently is considered only as a place to die.

Residents may have chosen to live in a nursing home because their eyesight and/or hearing is failing to the extent that they are unable to care for themselves. Some may be crippled with arthritis or have other prolonged or temporary illnesses. Some may have incapacitating diseases such as multiple sclerosis. Some may be disoriented, mentally disturbed or psychotic. Some may be physically incapacitated by accidents which resulted in limited physical mobility. Some may have lost control of their body functions which can not be managed in a home situation. Some may want the security of people always available to aid them with their aging frailties.

The older person who becomes a nursing home resident must adjust to changes within themselves such as: impairment of their senses; illness and discomfort; possibly defective memory; their specific handicaps; reduced physical and social attractiveness; and ultimately to ceasing to be - death.

Outside of themselves, the resident has had to adjust to a loss of productivity in a culture which is achievement oriented and one which is so youth-oriented that the aged are stripped of their value by forced retirement.

The University of Maryland Center on aging reports that older people are constantly reminded that getting old is no fun. Everything

is all downhill - intellectually, financially and sexually. Society offers only the expectation of inevitable decline. Butler has stated that these attitudes interfer with a realistic adjustment to old age. "...When one is old, there is really no effective way to escape the effects of a culture that denigrates age."[11]

At this time of life, many older people have lost the security, the affection, the companionship and the ego-support of many of their friends and family through death, moving, or detachment. They do not feel wanted, useful, or important to others. In Maslow's[12] hierarchy of human needs, social needs (giving and receiving friendship - interacting with others, and for social approval) is placed immediately after physiological and safety needs. They have the same desire to maintain self-respect and personal dignity as anyone at any age.

The aging individual now enters an institution where their individualism will be replaced by the routines of the facility. In order to be placed in an institution, one must give up one's home and a lifetime of treasures and memories for a room with starched sheets on the bed, a closet too small for clothes, and a stranger for a roomate. They will be immediately placed in contact with other residents who show varying degrees of physical, mental and emotional deterioration. The normal aging process combined with infirmities which are seen all around then produces more anxiety than they can tolerate. The new resident frequently closes all relationships and denies the aging process as much as possible.

It is difficult for the aging resident who has led a productive life to be placed in an impersonal, public institution with the resulting loss of control over his/her life. Residents are denied a lock on their door, and they can not control who or when anyone enters their room.

The resulting loss of identity and self-esteem often produces behavior which is difficult for the nursing staff to understand and manage. It is not unusual for the new resident to develop all types of psychopathology. Hypochondrical complaints are usually directed at ingestion, digestion, and excretion. Dr. Eugene Cohen suggests that often complaints about health shifts the blame for lack of performance from emotional inability to physical illness; thereby making it more acceptable.[13]

Severe depression as a result of being institutionalized may be considered senility because and only because of the person's age. Geist found that:

> The uprooting of the aged from their home surroundings may develop into all kinds of psychopathology. Reactive neurotic depressions are quite common. Symptoms of fatigue and incompetence, fantasy, excessive reminiscences, and hyrochondriosis are familiar patterns in these people.[14]

More and more frequently, experts in the field are accepting that psychiatric aid and counseling are needed and can be very beneficial to the aged.

Storandt[15] in discussing the psychological aspects of the elderly's adjustment to life situations states that basic inability to adjust, unaided, to a hearing loss may cause an aged person to withdraw from interpersonal relationships. The difficulty in communicating is too much for them to overcome. From this withdrawal, isolation, loneliness, depression, and a loss of morale may develop. The remedy is very simple if the cause of the withdrawal is diagnosed and effective therapeutic intervention is available.

She also states that many distrubances related to loss of sensory abilities are found in geriatric patients. For example, nocturnal restlessness, in the aged person, may be due to the reduced amount of sensory stimulation that is received. At night when the lights are low and all is quiet, less stimulation is received. The lack of stimulation results in a frightening experience for the resident who is living is an institution.

She concludes: "...many treatment techniques are appropriate to, and successful with, the elderly. Psychologic disturbances in old age are not necessarily incurable."[16]

Clinical studies of young, healthy subjects who were war prisoners demonstrated that these people reacted to prison life with confusion, disorientation and hallucinatory experiences.[17]

The monotony and isolation, lack of respect for personal privacy and integrity combined with the prisoners' awareness of their helplessness and possible death is paralled in the life of the residents in nursing homes.

The most impoverished people living in the community have some freedom of action, some choice in how they live each day. These choices are not available in nursing homes. Gossett further states that:

> We found the most prevailing and common characteristics of nursing home residents to be some degree of 'deterioration': apathy, withdrawal, isolation; loss of motivation; confusion and disorientation; depression and regression. It is not surprising to find this complex of depressive symptoms in the aged who suffer the extreme confinement and restrictions of institutions giving long term care today, since the basic characteristics of depression are ego inhibition (frustration) loss of self esteem and helplessness.[18]

Residents of nursing homes are cut off from participation in the community and their social needs are for the most part ignored.

> ...In one suburban area of Los Angeles County a senior citizens group was invited to a very attractive nursing home for a luncheon in an effort to help patients maintain contact with the outside community and counter-attack the 'prison atomsphere' of a nursing home. This group refused to come as it seemed they felt it would be too depressing and one would conjecture many were reacting to personal fears of nursing home placement.[19]

Aging does not change people into 'nothing'. They need old friends, and new friends; to be allowed to love and to be loved; new experiences; and control of their own lives to whatever extent they are capable.

Butler suggests that older people need to recognize their age, and take pride in it. They must learn to value others of their age so that they can support changes with a united practical action and psychological support.[20]

Mosley feels the elderly citizens are not complaining loud enough about their rights.[21]

The losses which affect the residents of institutions the most are the loss of self-worth--loss of value as a human being; loss of the ability to control their life and body; and lack of 'belonging'--of having a significant relationship with others. These losses point in the direction of death.

Cawdry expresses the problem this way: "...often the adaptation an elderly person must make is the ultimate learning how to die, to face not being."[22] Staff employees of institutions are products of the same society as the residents of those institutions. They hold the same impatience, fear, and inability to cope with the aging process.

Mensh has observed that doctors view older patients in terms of the disease process and that nurses tend to introduce social-psychological variables along with the disease process; social workers tend to ignore the physical disease problems and concentrate on socio-emotional and socio-cultural components of aging.[23]

A need for reorientation to the speciality of geriatrics is needed by physicians, registered nurses, and social workers.

"The physician...in many ways...has a shorter span of patience with the older patient who is less satisfying, slower to heal, quicker to relapse, so near to death.

He looks at the older patient with irritable eyes, recognizing human frailty and mortality for what it is."[24]

The registered nurse must recognize that a high percentage of the patients will not get well. Geriatric nurses find the intensified family and patient involvement very demanding.

"We (nurses) should take stock of ourselves and examine our real viewpoint on aging, the aged person and death. Our own philosophy of life is bound to show itself in our work with older people..."[25]

Until recently, social workers were not employed by nursing homes.

"For social workers, one wonders whether the profession itself fully accepts its role...In the not too distant past there has been real reluctance on the part of many to work with the chronically ill aged."[26]

The aged patient is a constant challenge to the health professional. Workers must not be discouraged by the lack of an outright cure. Performance of the patient must be improved if possible and if improvement is not possible, one must preserve what can be preserved. Medical treatment in the aged must be accompanied by increased awareness of the psychosocial needs of the aged.

> Illness and disability are not consequences of aging alone-there is always a disease process involved. Old people are normal people who may become ill, it has been said. The other normal people who become ill, they can be helped. The good physician manages his elderly patient with purpose and with hope.[27]

A majority of the personnel working in the long term care facilities are functioning on the aide level. These aides spend their total working hours in direct contact with the residents and are responsible for 80 percent of the patient care. More importantly, they are in daily contact with the residents and are expected to deal with the psychosocial needs of the residents. All this is expected without any, or very little, education or training and with very little monetary reward.

In a special report published by the Sub-Committee of the Special Committee on Aging, United States Senate, we find this statement:

> It would be difficult to find in our society a working role more deserving of recognition and less recognized. We assign to the group of workers the role and functions of family members. They

> give care which relatives and friends are not able to give. We believe that most often they do it with gentleness and compassion. Yet we fail to define the role or develop it by means of even the most minimal requirements.[28]

This report also included these pertinent facts:

1) Most nursing aides or orderlies receive no training for the job.

2) Fifty-three percent of them have no previous work experience.

3) They have little formal education -- only one-half of the 280,000 aides and orderlies are high school graduates.

4) Turnover rate is 75 percent a year.

5) Employed off the street. References are seldom checked.

6) Pay is usually the miminum wage. Job benefits are few.

7) Work is physically taxing and often unpleasant.

8) There is little hope for advancement and wages never get much beyond the minimum.[29]

Nurse's aides are given very little attention as individuals. Field work demonstrated that most aides feel that the supervisors ignore them. The aides frequently expressed a need for recognition and acceptance as an important part of the nursing staff.

A study of nursing personnel in a Pennsylvania nursing home found that the aides had a general interest in the nursing field but were dissatisfied with caring for the elderly. Field experience in a nursing home indicates that the aide is not very closely supervised. As a result, the aides have the power to give or to withhold care as they see it.[30]

A study of the humane treatment of old people in institutions was reported by Kahana. This report suggests that getting along with the attendants and aides may be the toughest task the institutionalized person faces.

> Attendants govern both the patient's position in the social system of other residents and his relationship to other staff. Getting along with the attendant may become the all important criterion for adjustment, of gaining recognition, and even of communicating with other staff people.[31]

A study done in a state mental hospital by Dunham and Winberg described the important influence of the power and control which the aides exercise over patients. Kahana confirmed these findings in another study of conforming behavior in a home for the aged. Here the staff evaluation of the resident adjustment were highly correlated with their degree of conformity.[32]

The aged patient who is not tolerated as an individual may cease to be a person. Large institutions often initiate and hasten this process to fit the individual into the needs of the routines of the facility.

It is a waste of valuable human resources when the employees of nursing homes are not supplied with the knowledge and skills which they need to give quality care to those whom they serve. Educational programs for aides who provide 80% of the resident contact is poorly planned and ineffective.

> From reports of aides and nurses and from observation, we have concluded that inservice training in many homes actually functions as a refresher course in nursing and personal care skills. Besides being redundant for an aide who has performed these tasks daily for several months, this is a gross underutilization of the potential value of a training program.[33]

Institutions have been mandated by federal regulations to provide inservice education. However, the method of presentation and the quality of the education has been left to the discretion of the health professionals. Health care professionals are committed to quality care but they have not assumed the responsibility for instituting the resources and providing the interest for the education needed to improve the skills and knowledge of the staff.

Inservice education will not remedy all problems in a facility. It will help to promote understanding of the goals of the home through orientation programming. It will develop skills which will result in the ability to do a job well. Training in new skills provides the personnel an opportunity to grow with their jobs. It will provide an opportunity to exchange information and ideas.

Inservice education will produce a higher level of resident care. It can provide a practical method for working out solutions to problems that develop in the institution. All these benefits will be reflected in the public image of the facility and most importantly in the quality of life offered to the residents.

In order to achieve the above results, inservice education must be on-going, planned and systematically presented. It will not be effective if the instruction is only a necessary act to satisfy code regulations.

Government standards have mandated the development of inservice education programs. The scope and basic components of such programs must come from the facility and the needs of the personnel.

Many nursing homes, in order to meet the government regulation which requires an inservice program, restrict the teaching to task-oriented skills. The regulation concerned with inservice education is as follows:

> For the purpose of improving care and services within the facility, there shall be an active inservice training program for nursing personnel. Such training should be corrdinated by the Director of Nursing Service and shall include a thorough orientation program for all nursing personnel; skill training in nursing procedures; restorative nursing measures; and other measures concerning the welfare and safety of the patients.[34]

The above regulation does not specify the teaching of skills which would help the employee gain job satisfaction nor does it provide for the teaching of interpersonal skills.

Mayne defines inservice education in this way:

> Inservice education holds a prominent place in the triad of activities, along with selection and assignment and supervision and evaluation, which forms the base for staff development. It is an on-going process which assists an employee to function at her highest level of capacity. It provides a means for the realization of personal as well as job goals through self improvement, job satisfaction, and the opportunity to make a maximum contribution toward the improvement of patient care.[35]

Nodell has definition of inservice education divided into the values

it offers for the staff, the home, and most importantly, for the resident.

The staff receives from inservice education the following:

1. Orientation to the work environment
2. Skill training
3. Refresher information
4. Opportunity to grow on the job
5. Adds new insights and understanding to the job
6. Checks on job performance
7. Develops efficiency on the job which results in job satisfaction

The nursing home would receive:

1. Higher level of care for residents
2. A more efficient staff
3. A laboratory for the analysis of home's problems
4. A discussion group for the resolution of inter-personal or inter-departmental disagreements.
5. Hidden grievances are brought to the surface and their solution may reduce staff turnover.

The resident receives:

1. More skillful and experienced attention
2. More consideration as an individual
3. More attention to specific needs - physical, social, emotional, spiritual.[36]

Many of the difficulties encountered on the job are the direct result of lack of knowledge of the aging person. Field experience has taught that loving care is not enough and that the intellectual ability to cope with the minds of the residents cannot be put into uneducated staff hands.

This paper is committed to the idea that inservice education is necessary and will produce better quality care and raise the morale of the staff.

CONCLUSION

As a result of public criticism which was given wide media coverage in the last decade, progress is slowly being made in improving the physical plants of long term care facilities. Most of these changes are related to the safety of the residents. Structures are required to be fireproof with exists spaced conveniently. Ramps and handrails are being installed to aid those whose mobility is limited. Particular attention is being given to lighting, sound proofing, and individual temperature control.

The quality of life which is offered to the residents of institutions has been mostly concerned with keeping them safe, dry, and quiet. Little concern has been shown for their psycho-social needs. Without a favorable psychological attitude toward the elderly's ability to adjust to new situations and relationships, other efforts in their behalf will be ineffective.

In 1972, The Long-term Care for the Elderly Research Review and Advisory Committee of Public Health Service defined quality care as follows:

> High quality, long term care is concerned with the total person as he relates to his family and consists of a complete range of care and services organized in the appropriate setting to help each individual achieve and maintain functional capacity at an optimal level in all dimensions of physical, social, economic, and psychological health. Moreover, it can be measured at the individual, institutional, and community levels.[37]

In order to achieve quality care, it is not enough to have a good facility and adequate numbers of personnel to provide care. Quality care can only be achieved by an alert administrative staff who organize services with emphasis on continuity of care and an understanding of the needs of the total individual - emotionally as well as physically.

Quality care can not be expected from nurse's aides who have little education and little or no preparation for the job they are doing even if

they do enjoy working with the elderly and are compassionate people. Love is not sufficient to meet the many needs of the institutionalized elderly person. Harper has made this ovservation: "...Where love of man is, there also is love of this art. But love of man must be clarified by an understanding of man and must take note of his social environment and economic needs."[38]

Research reported elsewhere in this paper has proven that nurses' aides respond well to education. They have an interest in learning more about their job and did take an active part in the educational program. If a planned for, controlled, and guided inservice education program is not offered, the inservice learning will take place in the employment situation. This type of learning can result in poor working habits, acquisition of inaccurate information, attitudes and behavior which may not be in the best interest of the resident. The question then is not why should we start inservice education but when should we begin?

Inservice education must be a planned, sequential process that has as its goal improved quality of care for the residents. Objectives to be formulated to give direction to the program, to set the course of teaching, and to express the results expected.

Inservice programs must be tailored for the personnel in the specific facility. The interest and desires of the personnel, the needs of the institution, and the crisis demands for knowledge which occur daily in a nursing home must be included in the inservice planning.

A handbook has been designed which will provide instructions for beginning an inservice program and a basic series of eight classes. These classes will deal with the psycho-social needs of the institutionalized elderly because it is in that area that the most help is needed.

There is no more efficient laboratory than the problems on the job which the staff faces each day. It is constantly supplying new material for study, new problems to be solved, and opportunities to practice what is learned in the classroom.

Inservice education works because improvement in quality of nursing care is brought about through nursing staff development and the members of the staff have a potential for personal growth and the capacity to learn and improve job effectiveness and efficiency.

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5. Ibid, p. 2221.

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APPENDIX

A TEACHING MANUAL

A SUGGESTED PROGRAM

FOR A NURSING HOME INSERVICE

EDUCATION PROGRAM

FOR

MEETING PSYCHOSOCIAL NEEDS

OF

INSTITUTIONALIZED ELDERLY

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Introduction

The philosophy of inservice education is that quality care will be achieved by providing the nursing staff including all paraprofessionals with the necessary knowledge and skills.

The needs of the elderly who are living in nursing homes requres a very different type of nursing care than that provided in a general hospital setting. To be technically competent is not enough. The purpose is to develop a deep and meaningful relationship with the elderly one day at a time. Aging is not a disease and therefore is not curable. It is a phase of living that may require many types of aid and demand patience and understanding from both the personnel and the residents in nursing homes.

The goal of this paper is to motivate the personnel in nursing homes to be aware of the challenge and satisfaction of geriatric care. More specifically, the goals will be aimed at changing the stereotyped attitudes of negativism toward aging which is so prevalent in our society. Since attitudes and skill in human relations are acquired, education and clinical experience can change how one perceives the elderly person's needs. Focusing on the positive aspects of geriatrics as well as the degenerative processes of aging can make working in close contact with the aged exciting and fun. In order to accomplish this, one must view aging as a natural sequence of life that is to be lived.

In order to personalize the care of residents in institutions, the personnel must concern themselves with the background of the person, the social and psychological implications of living in an institution, the personal interests of the person, specific physical problems which the person may have, and most of all, the attitude the person holds toward themselves.

All these needs other than those directly concerned with physical well

being are called psychosocial needs, and encompass mental emotional and social needs. These needs - psychosocial needs - must be met if the residents is to learn to 'live' not just 'exist' in an institutional setting.

Since nures' aides have very little training for their jobs, educating them to deal with the total personality of the resident is essential. This teaching is most easily done in the clinical setting with a well-organized inservice education program.

An inservice program must be more than just an orientation to the basic skills of care. It must be a systematic process with statements of general and specific objectives. Needs must be assessed, problems stated and a program of action developed. Implementing the program and evaluating the results must be planned to meet changing needs and solve new problems. Methodology is a matter of personal preference.

This teaching manual is concerned specifically with the psychosocial needs of the residents because it is in this area that the most help is needed. No one will criticize the employee who does not take time to talk and really listen to an institutionalized person. However, it is most difficult to define and teach the concept of caring. This manual is designed to offer the nursing home staff a source of information and a form for the teaching of psychosocial needs.

Although the teaching manual may be used as presented, it was designed as a guide for developing an inservice educational program which could meet the needs of any long term care institution.

The quality of care will be improved when the personnel are educated to be aware of and deal with the emotional and social needs of the institutionalized elderly.

Overview of the Teaching Guide

Goal: To provide better understanding of the mental health and psychosocial needs of the residents in order to cope more effectively with all residents--not just the problem cases--in order to raise the quality of life possible in an institution.

Objectives: Effect attitudinal change toward geriatric patients and the aging individual.

Provide necessary knowledge and skills to aid in dealing with aging oriented problems.

Improve the self-image and self-worth of the individual aide.

To be given to:

Specifically nursing aides and any other interested personnel including housekeeping and dietary department personnel.

Number of Sessions:

8-10 one hour sessions each week for 8-10 weeks.

Optimal Number of Students:

6-10 persons

Place: On the job

Time: 1 - 2 hours per session

Certificate will be given to those who attend 80% of the sessions, take a pretest and a post-test and complete all assignments.

A Special Note for the Nursing Home Administrator

It is my firm belief that if we have the means to keep people alive well into their eighties, we have the means to keep them enjoy living those years. As a result of this belief, I have tried to formulate a teaching guide to be used in nursing homes. This plan is aimed at the nurse's aides because of all your employees they are the ones who have the most direct constant contact with the residents. I have limited the plan to the emotional and social needs of the residents. This is not to take away from the necessity of teaching physical care, but, is in recognition of the fact that physical care is usually given the institution's full attention and psychosocial needs may be neglected.

Nursing homes bring their employees face to face with their own fears and feelings about growing old. Training programs can help the staff to examine the attitudes which they hold and enable them to develop a more humanistic approach to the care of the elderly. Employees who are functioning from an educated point of view will be more satisfied with their jobs, give more sensitive care, and perhaps last longer on the job.

The cost of this program is very small. An inservice educator is necessary if the program is to be successful. Materials are a very minor cost because most of the resources are present in your institution. Books, movies, and slides are available from public libraries. The inservice educator needs the support of the administration. Rules and regulations must be established by you if the staff is to be allowed to attend classes. A time and place must be provided and perhaps some recognition or compensation could come from the administration for those employees who seriously accept and participate in the educational program. Employee motivation is one factor in patient care which the administration can control. The administrative

staff can set the stage, the tone, the goals, and provide the optimism for the training program. A suggested agreement form is included for your evaluation. Perhaps it would not be suitable for your institution but it can be used to stimulate thinking. A form such as this is an approval of the inservice educational program and will provide a good basis for its success.

Most of the aides in nursing homes care about the elderly and about the type of job they are doing. They do not possess the skills to understand the value of their relationship to those in their care. If they are taught to relate to the residents as individuals and are given recognition for compassionate care, the institution as well as the residents will benefit.

Inservice education is the most economical method available for improving the quality of care in your institution.

Administrative Agreement

1. To provide full access to facilities and rooms.
2. Access to residents and resident's records, with release forms if necessary.
3. Scheduling - assist by requiring or reimbursing staff for participation. Provide for regular schedule to insure continuity.
4. Requiring that representatives from the administrative staff (head nurses, directors) participate.
5. Open the sessions to ancillary staff from housekeeping and dietary departments.
6. Provide suitable space with good light, comfortable chairs, blackboard. Provide projector for films and slide projection.
7. Give staff a chance to try the classroom skills they are learning.
8. Agree to some form of a certificate for those who apply themselves to the goals of the learning sessions.

Reward Suggestions:

Release time for class

Advancement of base salaries

A pin to be worn on uniform when course is completed

Career advancement

Certificate of completion

Suggestions For The Instructor

1. Keep the inservice program simple and direct.

2. Select a compatable group for each session.

3. Utilize clinical resources so that the students may receive immediate help with their most difficult problems.

4. Do not become so involved with the physical care of the elderly that you forget to stress the mental, emotional, social, and spiritual needs of the institutionalized person.

5. Motivating the employee to learn is most important because many of these nurse's aides have not finished high school and do not value education. Praise and recognition are useful motivating devices.

6. Plan a logical sequence of topics which you wish to cover and set priorities for your teaching.

7. Encourage staff to suggest topics, problems that need to be solved, and special interests which they wish to explore.

8. Engage the staff in the teaching activity when possible.

9. Select the teaching method most suited to the topic. Teaching a skill may require a different approach from that which would be used to teach a class aimed at changing attitudes.

10. Constantly check your equipment. Is the projector, tape recorder, or other equipment in working order?

11. Preview any films or other visual aids to make sure that they are in good condition and suitable for your class.

12. When using other resource people, always check the day before your session to verify their appearance.

Most important: These lesson plans are offered as a guide to you. They may be used as they are or they may be changed to meet your needs and situations.

Some Problem Areas In the Institution Related to Psychosocial Needs

The Resident

The resident who does not appear interested in helping himself.

The resident who wanders away unless closely watched or restrained.

The resident who rarely speaks, moves, or shows interest in anything.

The resident who has frequent outbursts of anger or aggression.

The resident who constantly complains or manipulates.

The resident who is overly suspicious and fearful.

The resident who is excessively noisy.

The resident who masturbates, exposes himself, or makes sexual advances.

The resident who wishes to die.

The Relatives

The relative who frequently criticises the staff.

The relative who appears to have a destructive effect on the resident's behavior.

The Staff

High turnover and absenteeism among the staff.

Low staff morale.

Teaching Methodologies:

1. Didactic teaching
2. Discussions
3. Group activities
4. Role Playing
5. Films
6. Clinical Materials
7. Pretests--Post-tests
8. Student Conferences

Instructor's Evaluation Sheet

The following is a suggested form for evaluating the sessions. It may be altered to meet the needs of your students.

1. Session Number ____

   Pre-session preparation:

   a. Was the class posted or announced:
      ____yes
      ____no

   b. Did the staff understand the goal of the session?
      ____yes
      ____no

   c. What percentage of the staff talked?
      ____25%
      ____25-49%
      ____50-74%
      ____75-89%
      ____90-100%

   d. Did the staff ask questions?
      ____very much
      ____somewhat
      ____a little
      ____not at all

   e. Did the staff volunteer new information?
      ____very much
      ____somewhat
      ____a little
      ____not at all

   f. Did the staff suggest specific topics for the future
      ____yes
      ____no

   g. General Comments:

UNIT I

Session I

Introduction to the Psychosical

Care of the Aged

Lesson Plan

Hand Out

UNIT I
Session I

Introduction to the Psychosocial Care of the Aged

Scope of this unit:

1. To provide a time for instructors and students to become acquainted.
2. To present the overall goals of the course and the course outline.
3. To view th movie "Aging" which will provide the student with an overview of patterns of aging and adaptation.

Time to complete: 1-½ hours

Place: Conference Room

Method: Short lecture
Discussion of outline
Movie

Materials: Movie: "Aging"
Projector and screen
Blackboard

Assignment:

1. Draw a picture of yourself as you think you will look at 80 years of age.
2. List ten physical or behavioral characteristics of one of your patients.

Handout: Course Outline

Evaluation Test

Instructional Objective	Activities	Resource Materials	Experience Charts
1. To develop an atmosphere in which the students will feel comfortable about starting an educational program.	1. Introduce staff and students, provide name tags. Have each student tell where and what type of work they do.	Name tags.	Becomes familiar with other students and faculty. Has a chance to take an active part in a structured non-threatening activity.
2. To give the students an overview of what the course will present.	2. Pass out course outlines and go over it in detail with the students. Request feedback.	Course Outlines.	Becomes aware of what will be expected by the instructor.
3. To evaluate knowledge of aging.	3. Administer evaluation test.	Test Sheets	
4. To lead the student into approaching their clients as individuals with varying desires and needs.	4. Show film - 22 min. "Aging".	Film "Aging" color, 22 min. Projector Screen	Learns about different problems of aging.
5. To encourage interest and continued participation in the program.	5. Explain assignment		

Evaluation Test

This is a true or false test devised by Dr. Erdman Palmore of the Duke University Center for the Study of Aging and Human Development to test public awareness of facts about old people and aging.

1. The majority of old people (defined as those over 65) are senile. True ____ False ____

2. All five senses tend to decline in old age. True ____ False ____

3. Most old people have no interest in, or capacity for, sexual relations. True ____ False ____

4. Lung capacity tends to decline in old age. True ____ False ____

5. The majority of old people feel miserable all of the time. True ____ False ____

6. Physical strength tends to decline in old age. True ____ False ____

7. At least 1/10th of the aged live in extended care institutions (nursing homes, mental hospitals, etc.). True ____ False ____

8. Aged drivers have fewer accidents per person than drivers under age 65. True ____ False ____

9. Most older workers cannot work as effectively as younger workers. True ____ False ____

10. About 80 percent of the aged are healthy enough to carry out their normal activities. True ____ False ____

11. Most old people are set in their ways and unable to change. True ____ False ____

12. Old people usually take longer to learn something new. True ____ False ____

13. It is almost impossible for most old people to learn new things. True ____ False ____

14. The reaction time of most old people tends to be slower than the reaction time of young people. True ____ False ____

15. In general, most old people are pretty much alike. True ____ False ____

16. The majority of old people are seldom bored. True ____ False ____

17. The majority of old people are socially isolated and lonely. True ____ False ____

18. Older workers have fewer accidents than younger workers. True ____ False ____

19. More than 15 percent of the U.S. population is now age 65 or over. True ____ False ____

20. Most medical practitioners tend to give low priority to the aged. True ____ False ____

21. The majority of older people have incomes below the poverty level (as defined by the federal government). True ____ False ____

22. The majority of older people are working or would like to have some kind of work to do (including housework or volunteer work). True ____ False ____

23. Older people tend to become more religious as they age. True ____ False ____

24. The majority of old people are seldom irritated or angry. True ____ False ____

25. The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be about the same as that of today's older people. True ____ False ____

Course Outline

Unit I Session I	Introduction to the Psychosocial Care of the Aged
	Movie "Aging"
	Handouts
	Course Outline
	Evaluation Test
Unit II Session II	Physical Aspects of Aging
	Handout
	"A Look at Aging"
Unit III Session III	Psychological Needs of the Institutionalized Elderly
Part I	Handout
	"Human Needs"
Unit III Session IV	Psychological Needs of the Institutionalized Elderly
Part II	Movie "Peege"
	Handout
	"Geriatric Patients are not Pediatric Patients"
Unit IV Session V	The New Resident
	Movie "The Eye of the Beholder"
	Handout
	"Patient's Bill Of Rights"

Unit V
Session VI

Communication Skills

Handout

"Communication Pretest"

"Communication-Interpersonal Techniques"

Unit VI
Session VII

Death and Dying

Part I

Handout

"Five Stages of Grief"

Unit VI
Session VIII

Death and Dying

Part II

Grief Process

Handout

"Self-Evaluation Sheet"

UNIT II

Session II

Physical Aspects of Aging

Lesson Plan

Handout

"A Look At Aging"

UNIT II
Session II

Physical Aspects of Aging

Scope of this unit:

1. To identify the physical impairments which accompany normal aging.
2. To demonstrate how physical losses affect the life style of the elderly by affecting perception of reality and functioning ability.

Time to complete: 1-½ hours

Place: Conference Room

Method:

1. Simulation
2. Lecture

Materials:

1. Wheelchair
2. Heavy mittens
3. Bag with assorted objects
4. Pencil and paper
5. Goggle Kit (simulates faulty sight perception)
   Pentagon Devices Corporation
   21 Harriett Drive
   Syosset, N.Y. 11791
6. Record "Getting through--A Guide to Better Understanding of the Hard of Hearing"
   Beltone Hearing Aid Company
   Chicago, Illinois
7. Record player

Assignment:

1. Observe patient with visual impairment.
2. List 5 ways to help the patient adjust to the loss of vision.

Handouts: "A Look At Aging"

Instructional Objectives	Activities	Resource Materials	Experience Charts
1. Demonstrate understanding of (a) loss of functional mobility (b) loss of sight (c) paralysis of one side of the body.	1. (a) ride and drive wheelchair. Try to pick up objects while wearing heavy mittens. (b) Place several objects in a bag and have student identify each object by placing hand in bag. Wear goggles which simulates changes in sight perception. (c) Write with opposite hand. (d) Listen to a record which simulates hearing loss.	Wheelchair Heavy mittens Pillow case containing 5 objects: spool of thread, tube of toothpaste, emory board, glasses case, bottle hand lotion. Goggle kit pencil & paper, Record and player.	(a) Learn the difficulty involved in maneuvering a wheelchair Working while wearing mittens demonstrated the difficulty that arthritic joints produce. (b) Student learned about limitations produced by visual problems. (c) Learned how difficult it would be to adjust to a paralysis of a hand. (d) Learned about different degrees of hearing loss and the confusion it produces.
2. To recognize physical changes in the elderly which affect: (a) appearance	2. Discuss the effects of aging on the systems of the body. a. Connective tissue changes (bone, blood, cartilage, and fat). b. Weight loss or gain c. Loss of hair or gray hair. d. Wrinkled skin Above are caused by skin's decreasing ability to nourish		2. Recognizes the necessity for allowing the elderly more time to do the daily tasks. Learns to be aware of the possibility that the client is not hearing or seeing too well and that the deficiency is reflected in his actions.

Instructional Objectives	Activities	Resource Materials	Experience Charts
	itself and hair properly. Layer of fat just below skin is lost as one ages.	Burnside, Irene. Psychosocial Nursing Care of the Aged. New York. McGraw Hill, 1973.	
(b) Mobility	(b) Motor changes- muscle tissue loses its elasticity and reserve energy ability. Retarded reflexes and slower adjustment to stimuli produce problems. Tremors, shaking, paralysis, increased brittleness of bones. Mental confusion (forgetfulness, irritability).		
(c) Sensory Perception	(c) Sensory changes- progressive loss of sense of smell and taste. Progressive loss of tactile sense. Visual- presbyopia-slower adjustment to changes in light and a loss of peripheral vision. Auditory-hearing ability decreases. Often people are not aware of not hearing. Often cannot hear the high pitched sounds.		
(d) Nutrition	(d) Gastro Intestinal Changes: 1. Digestion slows, absorption is less efficient; 2. loss		Understands the difficulties the elderly have with ingestion and

Instructional Objectives	Activities	Resource Materials	Experience Charts
	of digestive acids. 3. Intestinal activity is less efficient due to diminished peristalysis which causes constipation.		excretion.
(e) Cardiovascular System	(e) Cardivascular changes: 1. Decline in cardiac output and less capable of responding to extra work, 2. Arteries become more narrow and less blood passes through.		Learns the reason for allowing the elderly more time to go from one position to another.
(f) Respiratory System	(f) Changes in Respiratory System: 1. Total lung capacity decreases; 2. Reduction in vital capacity.		
(g) Urinary Tract	(g) Changes in the Urinary Tract: 1. Progressive decrease in the functional ability of the kidneys; 2. Polyuria and nocturia are common among the elderly.		Learns to accept the need of the elderly for frequent urination.
(h) Reproductive System	(h) Changes in the System: Menopause in the female and male causes decrease in female breast and male testicles. Sex hormones continue to be secreted and the elderly continue to have sex needs.		Recognizes the needs of the elderly for interpersonal relationships on all levels.

A Look At Aging

It may never be possible to look forward to aging with all the decrements which advanced age brings but modern interest and research is providing options for a more satisfactory future for the elderly. It is important to concentrate and build on the gains that come with age.

Gains

1. Looks - more natural in personal style.
2. Friends - time spent with people is cherished.
3. Relationships with opposite sex are more open and honest.
4. More freedom to travel when it is convenient.
5. Free from demands of making money.
6. Time is available to pursue personal interests and hobbies.
7. Possesses inner security and peace which comes with experience.
8. Free from demands of rearing children.
9. Accumulative experience of a long life provide the ability to understand and enjoy the present.
10. Experience in living provides the skill to set priorities.
11. Freedom from society's pressure to conform.
12. Freedom from necessity to achieve.

Losses

1. Looks Change - hair gets grey; skin gets dry and wrinkled; may lose teeth.
2. Health - may have chronic diseases.
3. Friends by death or relocation.

4. Spouse by death or divorce.
5. Children scattered to different parts of the world.
6. Reduction of income - forced retirement.
7. Loss of meaningful work due to retirement.
8. Loss or decrease in ability to see and hear.
9. Loss of speed and flexibility in movement.
10. Possibility of loss of self-esteem. May become timid, uncertain, sensitive, suspicious.
11. Sacrifice of individuality, dignity and privacy if forced to enter an institution.
12. Familiar lifestyle frequently is drastically changed.

UNIT III

Session III

Part I

Psychological Needs of the

Institutionalized Elderly

Lesson Plan

Handout

"Human Needs"

UNIT III
Session III

Part I — <u>Psychological Needs of the Institutionalized Elderly</u>

Scope of this unit:

1. To present the basic psychological needs of human beings necessary to achieve quality of life which must be met if they are to have a good quality of life.

2. To recognize that the aged have special needs that require care.

3. To show that residents of institutions have more difficulty in satisfying these needs.

Time to complete: 1 hour

Place: Conference Room

Method: Lecture-Discussion-1 hour

Materials: None

Student Assignment: None

Handouts: "Human Needs"

Instructional Objectives	Activities	Resource Materials	Experience Chart
1. To become familiar with the concept of human needs a. Physiological b. Psychological	1. Define need a. Physiological needs (food, shelter, air, water) b. Psychological needs (security, love, affection, respect of others pride in abilities, recognition from others).	Dr. Abraham Maslow's Chart of Five basic needs Maslow, A. Motivation and Personality. New York: Harper and Row, 1970.	Learn basic human needs which are common to all ages and ways of satisfying those needs.
2. To recognize needs which occur as a result of aging.	2. a. Discuss retirement (voluntary-involuntary) and the loss of psychosocial satisfaction previously received from job. b. Discuss the changes in living standards due to loss of monetary reward from work. c. Review physical losses from Unit II. d. Discuss living in nursing home because of circumstances beyond control (unable to meet their needs without assistance). e. Examine myths of aging held by our youth oriented society. "Aging is the end--old people are senile, sick and in institutions"--myths, not reality.		Learn the losses which are commonly experienced by the elderly. Examine the stereotyped attitudes expressed by today's youth-oriented society.

Instructional Objectives	Activities	Resource Materials	Experience Chart
3. To define living tasks and develop methods of providing assistance.	3. General: listen and really hear, be empathetic. Care. a. Allow the person to grieve, talk about the lost one, encourage contact with others. b. Respect individual's need to have personal belongings in their space--furniture, pictures, plants, etc. This brings in a part of "home". c. Take time to know the residents--take time to listen and discover their interests--direct them to activities with others in the home. d. Arrange trips to church, senior citizens' groups or other activities.	Handout - Human needs.	Gather ideas for helping the residents meet some of their needs. Learn to reach out and help residents get to know others.

Human Needs

Growing older does not change an individual's basic needs but it becomes increasingly more difficult to satisfy them. The elderly need attention, recognition, and acceptance in the same way that any age does. The elderly get to be elderly simply by living a long time.

Dr. Abraham Maslow has compiled a sequence of needs which all people must satisfy. He arranges them in a staircase progression because he feels that as one need is met, the move to satisfy another can begin.

Why I do What I do

I have five human needs. I do what I do because I must satisfy my needs.

For self-realization

For status

For meaningful social contacts

To feel secure

To survive

1st Step: To Survive: I need food, shelter, and air. If I am hungry, nothing else matters. If these needs are met, I can move up to:

2nd Step: To Feel Secure: I need to feel safe in the nursing home and within myself. I need to feel safe from external dangers (including people) that may harm me. If these needs are met, I can handle difficulties in a realistic way. If they are not met, I see the world as hostile and I behave in unacceptable ways.

3rd Step: For Meaningful Social Contacts: I need to share love and affection, I need to know I am wanted, and I need to know that I can give love. If this need is not met, I have no sense of belonging. This is commonly the very core of maladjusted behavior.

4th Step: <u>For status</u>: I need a sense of self-esteem, the respect of others, and pride in my abilities whatever they are. Otherwise, I feel helpless, discouraged, inferior, and weak.

5th Step: For Self-Realization: I need to continue to grow to my best possible self. When this need is met, I am everything it is possible for me to become.

There are times when people simply cannot "move up." This personal tragedy must be accepted. Handle the person with respect and consideration and somewhere within their emotionally ill self, they will feel your caring.

UNIT III

Session IV

Part II

Psychological Needs of the Elderly

Lesson Plan

Handout

"Geriatric Patients are not
Pediatric Patients"

UNIT III
Session IV

Part II Psychological Needs of the Institutionalized Elderly

Scope of this unit:	To provide insight into the relationship between the institutionalized elderly and their families.
Time to complete:	1 hour
Place:	Conference Room
Method:	Movie
Materials:	Projector Movie - "Peege", produced by David Knapp and Leonard Burnman - 1973; available at Public Library.
Student Assignment:	Read handout: Geriatric Patients are Not Pediatric Patients.
Handout:	Geriatric Patients are not Pediatric Patients

Educational Objectives	Activities	Resource Materials	Experience Chart
To help the student understand the difficulty in maintaining family relationships in institutions.	Show movie "Peege" Discuss: 1. How to approach someone who cannot talk or get out of a wheelchair. 2. The need to observe non-verbal communication. 3. The importance of touching as an aid to communication.	Projector Movie: "Peege" from Public library Produced by David Knapp and Leonard Burnman, 1973. Gramzow, C.J. "An Uncaring Attitude Taught me Nursing Care." RN, (December 1976) 39: 35-7.	Becomes aware of the strain that institutional living produces in the whole family. Sensitizes the student to the need for 'real conversation' with residents even if they appear to be confused.

Geriatric Patients Are Not Pediatric Patients

Geriatric patients are people who have led productive lives and were successful enough to have reached an advanced age.

The fact that these people are living in an institution does not change the type of person they were before entering the institution.

The basic emotional needs of human beings become extremely important when they are placed in a dependent position. For example, a man who had been an executive in a corporation may find it most exasperating to be called by his first name by people young enough to be his grandchildren. He would resent the lack of privacy, the lack of physical space, and the schedule of the institution which would deny him the choice of how to spend his time.

A female resident might share the above problems and because of her anatomical structure have additional problems with bladder leakage. For an adult, whose intellect is intact, to be faced with soiling their clothing or bed is extremely degrading. If the personnel treat this problem in an unfeeling way, the anxiety is compounded.

Often when working in the field, personnel are overheard discussing an aphasic patient as if the patient also could not hear or comprehend. This is very destructive to the mentally and emotionally alert patient.

Developing a sense of empathy, (visualizing yourself in the patient's position in order to try to understand their

their feelings) is perhaps the most important skill for one who is working with the institutionalized elderly.

Another important skill that needs to be developed is the ability to listen to both verbal and non-verbal messages. People communicate many of their emotions through body language. For example, a person who is afraid that the wheelchair may go too fast or turn over will often sit in one spot, clutching the arms of the chair. This situation requires the personnel to not only recognize the problem, but to teach the person how to drive the chair.

The following are some statements overheard in a nursing home which demonstrate the lack of respect for the residents as adults:

"You've wet the bed again!"

"It doesn't matter what you wear. Hurry and get dressed."

"So your daughter didn't come to see you! I guess she doesn't like nursing homes."

"Stop complaining. There is nothing wrong with you."

"You smell terrible!"

All of the above and others which can not be printed here were spoken in a loud voice and were not in response to any overt negative action on the part of the resident.

Think about these statements. How would you react to them if you were the patient?

Quality care requires honest concern and willingness to take the time to recognize people as individuals.

UNIT IV

Session V

The New Resident

Lesson Plan

Hand Out

" Patients' Bill of Rights"

UNIT IV
Session V

The New Resident

Scope of this unit:	1. To identify the problems in adjusting to life in an institution. 2. To use the knowledge of these problems to help make the transition less traumatic.
Time to complete:	1-½ hours
Place:	Conference Room
Method:	Lecture Case Study - Present a file on a recent admission to the unit. Movie: "The Eye of the Beholder" -- Actual experiences of different perceptions of the same event.
Materials:	Projector Screen Movie: "The Eye of the Beholder", Stuart Reynolds Productions, Inc. 9465 Wilshire Blvd., Beverly Hills, Ca. 90212; Public Library.
Student Assignment:	List the possessions you would wish to bring with you to a nursing home.
Handouts:	" Patients Bill Of Rights"

Instructional Objectives	Activities	Resource Materials	Experience Chart
1. To understand the necessity for living in a nursing home. a. Physical disabilities. b. Mental abberations.	1. Have students discuss decisions made this morning re " 1. how to spend the day, 2. what to wear, 3. what and when to eat. a. Would these decisions have been altered if the student had 1. severe arthritis, 2. fractured bones, 3. paralysis of an arm or leg? b. Discuss the need of some residents to have decisions made for them.	Case history from the department of a new admission with whom students are familiar.	1. Learn to see the resident as a person who needs assistance with living.
2. To understand the drastic change in the life style of these people. a. Loss of privacy b. Loss of posessions c. Loss of family d. Loss of independence and authority over their own lives.	2. Use case history to demonstrate specifics of the individual's losses. Did they: (a) have a choice in roommates?; (b) leave a large home? (c) bring only a few clothes? (d) lose a spouse by death? (e) lose control over their personal finances?		2. Learn to recognize the extent to which living in an institution changes one's lifestyle.
3. To be able to recognize and understand the fears which the new resident has-- a. Lack of freedom b. Regimentation c. Reduction of personal space d. Living in close contact with others whom they do not select.	3. How does the client in the case study relate to their roommate? How does this client care for their personal possessions? Does this client use the public spaces provided? What can you do to help this client?	Case history which demonstrates the adjustment of a recent admission to the institution.	3. Learn to recognize the fears that are produced when one's choice of lifestyle is taken away.

Instructional Objectives	Activities	Resource Materials	Experience Chart
4. To recognize that some undesirable behavior may be a reaction to fears of living in an institution. a. Withdrawing b. Loss of appetite c. Becoming incontinent d. Refusal to use aids such as crutches, walkers, hearing aids.	4. List clients who exhibit undesirable behavior which is destructive to their capacity to live a full life: Is this behavior progressive? Do you see evidences of accelerated physical decline since admission to the facility? Emotional factors which may be responsible for this decline are: 1 Suppression 2 Regression Develop a plan which will help this client adjust to life in the nursing home.	Present ongoing problems on the job. Jacobs, Ruth Harriet. "One Way Street: An Intimate View of Adjustment to a Home for the Aged." The Gerontologist (Winter 1969) Vol. 9, No. 4.	Learns to equate cause and effect in behavior of individuals.
5. To demonstrate that the perception of life is an individual experience.	5. Show film: "The Eye of the Beholder," 25 mins. Discuss experiences on the job that demonstrate differences in perception of the same event.	Film: "The Eye of the Beholder", Stuart Reynolds Productions, Inc. Public Library. Projector Screen	Views actual experiences of individual differences in perception of the same event.

Patient's Bill of Rights

Under federal and state regulations, nursing homes must have written policies covering the rights and responsibilities of patients. They are required to make these policies available to patients and the public.

A copy of the bill of rights taken from the Federal Register follows:

These "bill of rights" insure that each patient admitted to a nursing home:

1. Is fully informed, as evidenced by the patient's written acknowledgement, prior to or at the time of admission and during his stay, of his rights and of all rules and regulations governing patient conduct and responsibilities;

2. Is fully informed, prior to or at the time of admission and during his stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIX of facility's basic per diem rate;

3. Is fully informed, by a physician, of his medical condition unless medically contra-indicated (as documented by a physician in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

4. Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for non-payment of his stay (except as prohibited by Titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to insure orderly transfer or discharge, and such actions are documented in his medical record;

5. Is encouraged and assisted, throughout the period of his stay, to exercise his rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. May manage his personal financial affairs, or may have access to records of financial transactions made on his behalf at least once a month and is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. Is free from mental and physical abuse, and free from chemical and, except in emergencies, physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others;

8. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except in case of his transfer to another health care institution, or as required by law or third-party payment contract;

9. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

10. Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

11. May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his medical record);

12. May meet with, and participate in, activities of social, religious, and community groups at his discretion, unless medically contraindicated (as documented by his physician in his medical record);

13. May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically contraindicated (as documented by his physician in his medical record); and

14. If married, is assured privacy for visits by his or her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record).*

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*Department of Health, Education and Welfare, Social Security Administration, Skilled Nursing Facilities, Health Insurance for the Aged and Disabled; General Administration, Federal Register, October 3, 1974, Vol. 39, No. 193, pp. 35775-35776.

UNIT V

Session VI

Communication Skills

Lesson Plan

Handout

"Communication Pre-test"

"Communication Inter-
personal Techniques"

UNIT IV

Session VI

Communication Skills

Scope of Unit:

1. Develop the ability to listen.
2. To recognize that listening and responding to geriatric patients will give them the acceptance they need as individuals.
3. To demonstrate listening with understanding: What is the person really saying?

Time to complete: 1-½ hours

Place: Conference Room

Method: Pre-Test —
Game Playing: "The Rumor Game"
Role Playing
Tape Recording

Materials: Tape recorder
Tape

Student Assignment: List five examples of verbal communication with a client.

List five examples of non-verbal communication with a client.

Handouts:

1. Pre-test
2. Communication - Interpersonal Techniques

Instructional Objectives	Activities	Resource Materials	Experience Chart
1. To demonstrate how each person learns and listens differently.	1. (a) Students sit around the conference table (note to Instructor: write a rumor frequently heard in your facility on paper). Whisper the rumor to one student. That student will whisper it to the person on the right and so on all around the table. Last student reports the message aloud. (b) Pre-test.	Rumor Game Farrell, Marie; Haley, Mary; Magnasco, John. "Teaching Interpersonal Skills." <u>Nursing Outlook (May 1977)</u>, Vol 25, No. 5.	Learns how messages change between the mouth of the speaker and the ear of the listener.
2. To demonstrate how emotional involvement of the listener affects his reception and understanding of messages.	2. At the beginning of the session, the instructor mentions a "vague rumor" of a cut back in the staff but is careful to say nothing else. At the end of the class repeat the rumor and then allow a spontaneous discussion. After five minutes, stop the discussion. Ask the students to repeat what was heard at the beginning of the session. Discuss differences in perception.	Rumor Game Miller, Duley B. "Physical Communication In a Nursing Home Setting." <u>The Gerontologist (Autumn 1976)</u> 12 (3, pt. 1), 285-229. Tape Recorder	Learns how emotions and interest affect what we hear.

Instructional Objectives	Activities	Resource Materials	Experience Chart
3. To demonstrate the importance of the manner and tonal quality of speech in conveying feelings and attitudes.	3. (a) Have students listen to the thirty-second report of weather recorded by the instructor. Play the second recording of the message. Have students report what they heard. Discuss emotional reaction to the tape.	Tape report of weather recorded by Instructor in an angry tone. Another tape report of weather recorded by Instructor in a happy, excited voice.	Learned that the acutal message may have been lost in the words spoken.
	(b) Have students do the following exercise: Say / With / To Express oh-h-h-h / Rising Inflection / Surprise Excitement oh-h-h-h / No Inflection / Boredom oh-h-h-h / Falling Inflection / Disappointment Discuss the effect of voice tone on meaning of what is said.		Learns that emotional response is shown by tonal quality of speech.
4. To demonstrate the non-verbal responses such as gestures, facial expression, tone of voice, manner of speaking, and physical activity.	4. Pass out handout of Communication - Interpersonal Techniques. Discuss each of the 10 therapeutic techniques and the 5 non-therapeutic techniques.		Learns to notice not only what the client is saying to them but to observe the non-verbal communication which is being presented.

Communication Pretest

1. The family reports that Grandpa will not eat. The nurse says to the patient:

    a. Why won't you eat?
    b. Was there something about your meal that you didn't like?
    c. You upset your family by not eating.
    d. The doctor says you must eat to keep your strength up.

2. Two aides talking. One says, "There goes 202's light again. What does she want now!" The nurse should:

    a. Go and check the patient.
    b. Ask the aide what the problem is.
    c. Disconnect the buzzer light.
    d. Correct the aide for not calling the patient by name.

3. What is the best solution to the problem presented by this patient? "Why don't you ever remember that I want my newspaper before I get up in the morning?"

    a. Don't worry about it--a nursing home is not the place for maid service.
    b. Tape a note to the bed stating "give newspaper early in a.m."
    c. Use nursing care plan to notify staff.
    d. Ask night nurse to get a paper for him at 6 a.m.

4. The aide states that her patient is so deaf that he can't communicate. She should

    a. Speak louder
    b. Stand right in front of him
    c. Speak right into his ear
    d. Ask family if patient has a hearing aid

5. The charge nurse requests that Mr. Pitts be put in a chair. Later she finds him in bed. She should ask:

    a. Mr. Pitts, "Did the aide get you up?"
    b. The aide, "Why didn't you get Mr. Pitts up?"
    c. The aide, "Has Mr. Pitts been up yet?"
    d. Mr. Pitt's roommate, "Did the aide get Mr. Pitt's chair?"

Communication

Interpersonal Techniques

Therapeutic Techniques	Examples
1. Accepting	"Yes" "Uh huh" "I follow what you said" Nodding
2. Giving Recognition	"Good morning, Mr. X." "I notice that you've combed your hair" "I like your bright blouse."
3. Offering self	"I'll sit with you awhile" "I'll stay here with you" "I'm interested in your comfort"
4. Giving broad openings	"Is there something you'd like talk about?" "What are you thinking about?" "Where would you like to begin?"
5. Offering general leads	"Go on." "And then?" "Tell me about it."
6. Making observations	"You appear tense." "I notice that you're biting your lips." "It makes me uncomfortable when you ______________."
7. Encouraging description of perception	"Tell me when you feel anxious." "What is happening?"
8. Exploring	"Tell me more about that." "Would you describe it more fully?" "What kind of work?"
9. Giving Information	"My name is ________________." "Visiting hours are ____________." "My purpose in being here is _____." "I'm taking you to ______________."
10. Presenting Reality	"Today is Monday." "It is lunch time." "This is December 20, 1977."

Non-Therapeutic Techniques	Examples
1. Rejecting	"I don't want to hear about ___________!"
2. Disapproving	"That's bad!" "I'd rather you wouldn't."
3. Disagreeing	"That's wrong." "I don't believe that."
4. Defending	"No one here would lie to you."
5. Requesting an explanation	"Why do you feel this way?"

UNIT VI

Session VII

Part I

Death and Dying

Lesson Plan

Handout

"Five Stages of Grief"

UNIT VI
Session VII

Part I — Death and Dying

Scope of Unit:	To become skilled in listening to and assisting a person to live through their reactions to the death experience. To develop an understanding of the grief process in those who are dying and in their families and friends.
Time to complete:	1 hour
Place:	Conference Room
Method of Instruction	Part I Panel discussion: 1. Chaplin 2. Social Worker 3. Nurse
Materials:	Case History of a terminally ill patient that is selected from the files by the instructor.
Student Assignment:	Read handout of grief reactions by Dr. Kubler Ross
Handouts:	Five Stages of Grief by Dr. Kubler Ross

Instructional Objectives	Activities	Resource Materials	Experience Chart
1. To understand the traditional reactions to death which results in an avoidance and denial of the event.	1. Discuss the denial of impending death by doctors, family, and friends; religious beliefs that offer a new birth; the mystery of death and the forced acceptance of death by everyone.	Local Clergy: 1. Jewish 2. Catholic 3. Protestant	Learns that a strong religious belief helps people adjust to dying.
2. To understand how the concept of death changes with age.	2. Discuss the fact that each age group has its own concept of death. a. The young child sees death as sleep. They expect the dead to come alive again. b. Teenagers have intense feelings concerning death; they usually think in religious or philosophical terms and concentrates on life after death. c. The young adult sees death as ending everything. d. Middle aged and elderly adults view death with a sense of futility.	<u>Working with Older People</u>, <u>Vol. 1</u>, H.E.W. Publication, 1974, pp. 76-81. On Death and Dying, Kubler Ross, Elizabeth. N.Y., 1969, MacMillan Co.	Sees that denial of impending death often makes a very strained relationship among family and friends. Becomes aware of the need to give different types of support to different age groups.
3. To formulate ideas of how to help a terminally ill person die with dignity in an institution.	Present case history of terminally ill patient. a. Is the dying person in a private room?	Case History of terminally ill patient to be taken from the files.	Learns to face personal fears of being confronted with a dying person.

Instructional Objectives	Activities	Resource Materials	Experience Chart
	b. Are family, friends and other residents in the home allowed to visit? c. Is the dying person allowed to talk of the "unique experience" they are living through? d. Are life supporting measures reasonable?		Accepts that a dying person can enjoy living to the very end. Learns to be open minded about an individual's right to die.

Five Stages of Grief

By Dr. Kubler-Ross

Grief may be defined as an intense emotional suffering experienced when a person has had a catastrophic loss. Grief may come at the loss of an arm, one's eyesight, a home, or the death of a loved one. Accepting the reality of the situation is the goal of the grieving process.

Dr. Kubler Ross places grief into five stages. These are very helpful in understanding the grief process. She presents them in this staircase process.

____ Acceptance

____ Depression

____ Bargaining

____ Anger

____ Denial or isolation

However, field experience has shown that all these steps may not be identifiable or in this order. They represent a guideline in order to help you when you are talking with either the dying person or the family. If you can recognize the steps, you will be able to help people move into acceptance.

1st Stage -- Denial and Isolation

When told of the death of a loved one, the first reaction is shock and disbelief. No one wants to deal with the sadness that a loss by death can cause. The person who is dying is losing their whole life and this is denied. A grieving person may go into shock. Shock reaction can last from twenty minutes to an hour, days, or weeks. This is a severe form of denial and isolation. It is an absolute refusal to accept the death. Physical signs of shock are deep sighing, chocking, dryness in the mouth and throat, sensations of emptiness, lack of power to go about routine duties, and chills. A grieving person may wish to withdraw, become depressed, exaggerate physical complaints.

This denial and isolation may be a very short period of time for some people and then they move on to the next step of grieving. Others may stay in the denial experience for hours. Remember to accept that the grieving person is doing all they can do at that time. Allow them time to deal with the denial.

Do not attempt to force the grieving person to admit to the death. A person will do that when they are able to survive the grief that will accompany accepting the death.

2nd Stage -- Anger

Many people react with anger when told that they are dying or that someone near them is dying or is dead. The grieving person may think but not say, "Why me?" "Why my loved one?" That is anger and it must be resolved if one is to successfully arrive at acceptance of death.

Anger may be directed at anyone. Frequently the nursing staff is the target of the anger from both the families and/or the dying person. Families may accuse the staff of giving poor medical care, not notifying them in advance of the death, or a variety of other complaints. The dying person may resent that the staff is strong and healthy. Another idea is that the dying person strikes out at the staff because they are not preventing the death.

Guilt about the loved one's death may be the result of a disagreement which occurred just before the death. For example, a man and his wife have an argument the day before his death. The wife feels that perhaps this argument contributed to his death. She lashes out at anyone present.

In order to move from this anger and guilt reaction, the person must live through it. Do not get angry in return. Be calm and firm. Accept the anger and guilt as a problem of grieving and not as a personal attack on you.

3rd Stage -- Bargaining

This is a difficult stage to understand. It is an effort to buy time; to postpone the coming death. Most people bargain with God for longer life in return for donations of money or a change in lifestyle. The person may bargain for a chance to do one very special thing. For example, see grandchild born.

Bargaining is the person's last chance to deny the reality of death. It is a helpful stage in the grieving process.

4th Stage -- Depression

In the grieving process, depression must be considered as a step upward. In this situation, depression indicates that the person grieving can no longer deny or ignore the reality of the coming death. None of us is capable of not being sad and depressed when we know that we are going to die.

The immediate reaction to the depression of a dying person is to try to cheer them up. Do not do this! The dying person is in the process of losing everything and everybody by the act of their own death. There is no bright side. Allow them to talk of their real sorrow. They need someone to accept their dying as a fact. They need someone to listen, to touch, to care, to cry, and most of all--someone who can live through the experience with them and not run away.

Crying is so important to the grief process. When a person cries, they are acknowledging the loss. It allows them to regress into a safer, more helpless state for a rest period. Then they gain strength to come out and face reality again.

Perhaps the relief that crying may give to the grieving person is the greatest gift you could give anyone.

5th Stage -- Acceptance

When a person reaches the final stage of acceptance, there is no joy. It is more like just calmly waiting. This is the time when just knowing that other people care about them and will take care of them is most important.

Not every person reaches this stage of acceptance. Many die while still angry or depressed. The stages do not always come in the same sequence. They may pass through some stages more than once. All people and their families have the same needs when confronted with death. They need tenderness, acceptance, and caring. If you have never experienced the death of a loved one, you may have more difficulty understanding the grief process. The most important support that you can give is to be there, to stay there, and to care.

Some special remarks about the grief in the families and friends of the patient are necessary. You will be the staff member who deals with them at the time the death occurs.

Release of feelings is essential. Death has ended a relationship. Those remaining must return to a routine and reinvest in new relationships and interests. Normal grief is open and expressed and this provides the space to move on in one's life.

Abnormal reactions attempt to cover the emotions, the pain and the sense of loss. Often circumstances prevent the reaction of grief being expressed. A young girl whose mother lost emotional control at the grandmother's funeral found that trying "to help mother" prevented the young girl from normal release of her own grief.

A stoic reaction of silence because the deceased "would wish us to be strong" will also block grief expression. Well meaning friends may require so much of the mourner's attention that grieving may be pushed aside. Friends may force denial on the mourner. Both of these acts prevent the necessary living through of the grief.

Those who are grieving need time to accept the loss, time to talk it out. The best support can be in providing the necessities of life (food, clothing, etc.) and the presence of a caring person. Those with delayed grief reactions need special care.

The study of death and dying should help you put your reactions and the reactions of others in the proper perspective.

UNIT VI

Session VIII

Part II

Death and Dying

Lesson Plan

Handout

Self-Evaluation test

UNIT VI
Session VIII

Part II

Death and Dying

Grief Process

Scope of Unit:	To accept that individuals experience grief in various ways, but, all need to be supported through the process.
Time to complete:	1 hour
Place:	Conference Room
Method of Instruction:	Lecture Discussion
Materials:	None
Student Assignment:	Take evaluation test
Handouts:	Self-evaluation Test

Instructional Objectives	Activities	Resource Materials	Experience Chart
1. To understand the grief process involved in the dying experience.	1. Define grief (an intense emotional suffering experienced when a person has a catastrophic loss).	Dr. Kubler Ross	
2. To gain a knowledge of the five stages of grief so that they may be recognized and dealt with when they occur.	2. (a) State the 5 stages of grief (denial or isolation, anger, bargaining, depression, and acceptance). (b) Points to remember when dealing with grief reactions: 1. grieving person is doing all he can at the moment; 2. be factual 3. when the grieving person reacts with anger, the staff must not react in a like manner. 4. do not try to cheer up the grieving person. 5. allow the grieving person to cry 6. Normal grief must be open and expressed 7. lend your presence as a caring person.		
3. To become aware of some abnormal reactions to grief.	3. (a) Stoic reactions, all outward signs of grief are cut off. Tension is turned inward and is not released. (b) Circumstances can prevent the expression of grief due to demands made by deceased (to be strong) or demands of friends who force so much activity on the mourner that the grief period is lost. Later they have trouble	Case history from field experience in nursing home.	Learns to see the importance of accepting the fact of death. Is made aware of the necessity to express grief openly.

Instructional Objectives	Activities	Resource Materials	Experience Chart
	accepting the loss. (c) A grieving person may become severely depressed and withdraw, denying the death. (d) A mourner may exaggerate physical complaints and become ill.		

Death and Dying

Self Evaluation:

I. Dying with dignity can be realized if the dying person is provided with:

a. a beautiful human experience
b. comfort measures
c. private, pleasant room
d. no "heroic measures"
e. all of the above

II. Place the following terms in proper order:

1. ____	a. bargaining
2. ____	b. anger
3. ____	c. denial
4. ____	d. acceptance
5. ____	e. depression

III. True or false:

1. Crying means that the person is accepting the fact of death. T. ____ F. ____

2. Stay away from the dying person and let them rest. T. ____ F. ____

3. Discuss dying openly with the relatives. T. ____ F. ____

4. The grief process is an unnatural emotional experience. T. ____ F. ____

5. Reinvestment in new relationships is necessary for the mourning person. T. ____ F. ____

GLOSSARY

abuse - to do wrong to another person.

affiliation - adopting as a close friend.

aging process- life from conception to death.

ambulate - to walk or to assist a patient in walking.

amplification - magnifying sound.

anoxia - deficiency of oxygen.

aphasia - loss of ability to speak.

assault - a threat or attempt to contact the body of another person without consent.

auditory - pertaining to the sense of hearing.

battery - the act of making unauthorized contact with the body of another.

blood pressure - the pressure exerted by the blood on the walls of any vessel.

body alignment - arranging the body in a straight or natural position.

cardiac - pertaining to the heart.

cataract - condition of the eye that impairs vision.

cerebral vascular accident - a stroke which results in permanent brain damage.

Cheyne - Stokes respiration - a form of respiration starting slow and shallow, then increasing in rate and deepness until it reaches a maximum. It then gradually slows down, eventually stopping for 10-20 seconds, then repeats all over again.

chronical age - actual age in years.

chronic illness - a disease having a slow onset and lasting for a long period of time.

coma - a state of unconsciousness.

congestive heart failure - a disease of the heart which results in an excessive retention of body fluids.

connective tissue - parts of the human body which support the body physically, i.e., bone, blood, cartilage and fat.

conscientious - done according to what one knows is right.

continent - able to control the passage of urine and feces.

<u>continuity of care</u> - as the responsibility for a patient's care is transferred from nurse to nurse and/or shift, the high quality of care is provided on a continuous basis. As these changes take place, the patient care does not change.

<u>covert behavior</u> - behavior which cannot be seen--the person can describe it to you.

<u>cumulative action</u> - sudden action of a drug after several doses have been given.

<u>cyanosis</u> - the blue-grey or purple discoloration of the skin due to an imbalance in the blood preventing oxygen from being used by the body in the normal manner.

<u>debilitated</u> - extremely weakened.

<u>decubitus ulcer</u> - bed sore.

<u>delusion</u> - a false belief--not consistent with reality.

<u>depression</u> - a state of morbid unhappiness.

<u>disoriented</u> - loss of one's bearings; loss of familiarity with one's surroundings; loss of one's bearings with respect to time, place (where one is), and/or person (who one is); the opposite of disoriented is oriented.

<u>drug idiosyncrasy</u> - an unusual, opposite, or lack of effect of a drug.

<u>dyspnea</u> - difficult breathing, sometimes painful.

<u>electrocardiogram</u> - a record of the human heart. It is used in diagnosing heart disease.

<u>emaciation</u> - a wasted, lean body condition.

<u>emesis</u> - stomach contents that have been vomited.

<u>emesis basin</u> - a container used to hold emesis as it is expelled (vomited); usually is kidney shaped.

<u>emphathy</u> - the ability to understand another person's feelings, emotions, and behavior and what they mean.

<u>environment</u> - surroundings and conditions which influence an organism.

<u>environmental cleaning</u> - effective housekeeping of patient and work areas.

<u>ethics</u> - a system governing medical conduct, including moral principles and standards.

<u>excretion</u> - the elimination of body waste.

feces/stool - human waste excreted from the bowel; a bowel movement.

gastrostomy tube - a tube entering the stomach through the abdominal wall via an incision.

genitalia - the organs of generation or reproduction.

geriatrics - the study and care of elderly person.

grief - deep distress or suffering cuased by loss.

hallucination - the perception of sights, sounds, etc. that are not actually present.

hypertension - high blood pressure.

hypochondria - a state of depression and anxiety regarding one's own state of health, often with imaginary illnesses.

hypotension - a condition occuring when a person's blood pressure is lower than normal.

illusion - a false perception, conception, or interpretation of what one sees, or where one is.

incontinent - inability to retain urine or feces, usually due to a loss of muscle control.

inhalation therapy - the administration of medicines, gases, or water vapors into the respiratory system.

institution - a facility such as a nursing home or hospital.

intravenous feeding - providing all the nutritional requirements for the patient via the veinous blood flow.

judgemental - to form an opinion or to evaluate.

liable - obligated according to the law.

love - a very strong feeling of affection or attachment to someone.

Medicaid - a program in which federal, state, and sometimes local governments share the costs of certain medical services.

Medicare - a federal program in which certain health insurance benefits are given to people who are 65 or over.

motivation - to provide a person with the desire to do something.

motor tissue - parts of the human body which cause motion, i.e., nervous system, muscular system.

need assessment - the ability to assess or determine immediate needs or desires of a patient accurately.

negligence - failure to do what a person of ordinary judgment would do, or doing what a reasonable person would not do.

non-verbal - behavior observed by actions rather than words.

obese - excessively fat.

occupational therapy - treatment used to help the patient contribute to his own recovery.

olfactory - pertaining to the sense of smell.

opposition - moving thumb out and around toward little finger.

overt behavior - behavior you can observe with your eyes.

pallor - lack of color in the skin, paleness.

paranoia - delusions of persecution.

pediatric - a human being under 12 years of age.

physical therapist - a person who carries out therapeutic and rehabilitative measures dealing particularly with muscles and bones.

podistrist - a person that treats foot disorders.

post-mortem care - care given to a person after he has died.

presbycusis - loss of hearing associated with aging.

presbyopia - loss of the ability of the eye to adjust to near and far objects.

priority - termining which of several things to do; the one that is the most important; the one of secondary importance, etc.

prognosis - the prediction of the end result of a disease, and the outlook based on it.

psychological needs - emotional needs or needs found in the mind rather than the body.

psychomatic illness - one which may be related to emotional factors.

pulse - the periodic thrust felt over arteries "in time" with the heartbeat.

reality orientation - placing the person in his environment.

regress - to move backward; to return to former behavior patterns.

rehabilitation - methods used to return use of body parts after loss.

rejection - a feeling of being below the worth of others.

relationship - two or more people dealing with each other.

remotivation - renewal of interest in living.

respiration - the taking in of oxygen, its use in the tissues and the giving off of carbon dioxide.

seizure - a condition where a group of certain symptoms or severe pain is present.

senile - pertaining to old age.

sensory stimulation - to stimulate any or all of the five senses of sight, hearing, taste, touch and smell.

sensory tissue - parts of the human body which receive stimuli from the external world - i.e., hearing, sight, taste, touch, and smell.

shock - an upset caused by inadequate blood circulation resulting in lowered blood pressure, a rapid, weak pulse, and pale, clammy skin.

side effects - conditions caused as a result of actions not of the original intent.

sitz bath - immersion of thighs, buttocks, and abdomen below the umbilicus in water.

sign - evidence of an illness or malfunction of the body visibly seen; does not require the patient to tell you about the way he feels.

sociological - refers to a study of behavior and functioning of human groups and societies.

spouse - a person's mate by marriage; a husband or wife.

stasis - a stagnation of fluid.

stroke - a paralysis, loss of memory, confusion, resulting from a loss of blood supply to the brain.

temperature - a degree of heat in a living body.

terminally ill - the state of having an illness which because of its nature can be expected to cause the person to die.

toxic - poison.

vital signs - temperature, pulse, respiration, blood pressure.

void - to urinate.