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Planning a Seminar on Aging to Disseminate Information to Personnel Working with the Aged

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PLANNING A SEMINAR ON AGING

TO DISSEMINATE INFORMATION TO PERSONNEL

WORKING WITH THE AGED

Oscar Raymond Gain Jr.,B.S., R.P.T.

A Digest Presented to the Faculty of the Graduate School of the Lindenwood Colleges in Partial Fulfillment of the Requirements for the Degree of Master of Art

1982

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DIGEST

The project consisted of planning and organizing a seminar for dissemination of information to persons working with the aged. From my ten years of experience in the health care profession, six of them were working with the aged population. I was surprised at my lack of knowledge about the older person. After attending the course as Lindenwood College my knowledge expanded from the biological to the social and psychological aspect of aging.

I decided to organize a seminar for local health personnel working with the aged in a thirty-mile radius of my residence. There were a total of six speakers including myself speaking about the biological, sociological and psychological aspect of aging in long term care facilities.

Although I sent information to local hospitals, there was not one person at the seminar from an acute care facility. Considering that the aged have more frequent and longer hospital stays than the younger population, I thought the hospitals would have sent at least one person. The long term facilities in the area usually send one or two persons.

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I felt after the seminar ended that it was well received and informative. The evaluation forms returned were all rated high, with only a few below average grading. Some of the attendees, a week after the seminar, informally stated how they appreciated and enjoyed the seminar. I am considering organizing another seminar on aging since there are still a large number of persons needing information about aging.

PLANNING A SEMINAR ON AGING TO DISSEMINATE INFORMATION TO PERSONNEL WORKING WITH THE AGED

Oscar Raymond Gain Jr.,B.S.,R.P.T.

A Culminating Project Presented to the Faculty of the Graduate School of the Lindenwood Colleges in Partial Fulfillment of the Requirements for the Degree of Master of Art

1982

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I wish to thank my wife for her untiring effort and encouragement for me to complete this project. Without her assistance the task would have been too formidable to accomplish.

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I. INTRODUCTION

Gerontology as defined by Webster's Dictionary is a scientific study of the phenomena of aging and the problems of the aged. Holistic, defined by Webster's Dictionary, emphasizes the organic or functional relation between parts and wholes. Combining the two you have an approach that is both scientific and holistic. There is a vast amount of material written on the social, biological and psychological aspects of aging, with a scientific explanation. The only problem is that each specialty tends to forget that a person is more than a biological study or a social problem. One cannot zoom in on one aspect of aging without considering the person as a whole. The older person may be rich and healthy but unless his social life is balanced, he would be lonely and depressed. This then could lead to biological problems and then financial problems, due to additional medical expenses.

Although there is a vast amount of knowledge written on the aged, the dissemination of this information is poor. I felt that there was a need to educate the health personnel that are caring for the aged. I had several years of experience working with the aged and was surprised at my lack of knowledge. This lead me to the

decision to give a seminar for dissemination of information.

I wanted to include all three aspects of aging which includes the social, biological and psychological aspect of aging in the seminar. Clark Tibbits, a founder of social gerontology defines the social aspect as "concern with the developmental and group behavior of adults following maturation and with social phenomena which gives rise to and arise out of the presence of older people in the population" (Atchley, 1980). The social aspect of aging is concerned with population growth and the economy of the country. If the country is in an inflationary period, the fixed income of the elderly would be affected. The make-up of the population is also changing. The average life expectancy in Roman times was 20 to 30 years, according to some authors(Shephard, 1978). The average life expectancy in the United States in 1970 was 71 years; 75 years for a woman and 67 years for a male (Atchley, 1980). According to one author there were 15,000 Americans over the age of 100 years in 1972 (Curtin, 1972). Besides the social aspect, the physical well being of a person is important. As a person ages the most frequent illnesses are strokes, arthritis, and trauma (Bennett, 1980). This leads to a decrease in the quality of life and activity. However,

according to Schrock, if a person remains physically active, the decrease of physical strength would be more gradual(Schrock, 1980). Reviewing literature on aging, the three health practices emphasized most frequently is regular physical activity, adequate rest and proper nutrition (Schrock, 1980). The psychological aspect of aging needs to be considered in addition to the social and physical. Maddox, in a study of the elderly, found that perceived health was less positive among persons with a history of depression, who felt neglected by others and whose morale was low (Tessler, 1962). The self-concept of the elderly person is important to his health. Palmore and Luikory have shown that among persons aged 45-64, self-rated health is the strongest correlate of life satisfaction (Tessler, 1962).

II. ASPECTS OF AGING

Before one can delve into an assessment of the education preparation necessary for providing quality health care to our geriatric population it is necessary to have an understanding of what the field of gerontology is and it's impact on society. Gerontology can be defined as the study of all aspects of aging. It is what we know about the causes and consequences of aging.

The term aging refers to the various biological, psychological, and social processes that result in relatively predictable changes in mature humans as they advance in chronological age (Butler, 1977). There are three inter-related but yet separate aspects to the study of aging. The first is the biological aspect.

The biological aspect deals with physical aging. There are numerous characteristics of physical aging. The skin is probably most noticeable. It tends to be wrinkled and rough and is more vulnerable to malignancies, bruises, loss of hair and dryness than that of younger people. Postural changes are also rather apparent. Joints, especiall the hips and knees, tend to stiffen and compressed spinal discs produce the

shorter, bent posture characteristic of many older people. Other physical changes which occur in aging deal with the nervous and circulatory system. Hardening of blood vessels (arteriosclerosis) may create circulatory problems in the brain, thus reducing the speed at which the nervous system can process information or send signals.

The circulatory system is probably most affected by the aging process. Failure of the circulatory system is the most common cause of death for people over 40 (Atchley, 1980). Heart disease or interrupted blood flow to the brain or heart are common among older people. At age 75, the probability of death from cardiovascular disease is 150 times higher than at age 35 (Atchley, 1980). These biological changes can have a significant impact on the psychological aspects of aging.

The psychology of aging encompasses the sensory and psychomotor processes, perception, mental ability, drives, motives, and emotions. Aging has been shown to produce an increase in sensory threshholds and a decline in sensory activity, however, few people experience sensory limits on activity prior to age 75. From a medical point of view these changes can have a significant influence.

The sensory changes that occur with aging can

have a significant impact on the patient's health status. Visual activity tends to decline markedly with the 40's. It creates an inability to focus on near objects, which hampers his ability to read (Bolwinick, 1978); a problem perhaps in reading the directions on a medicine bottle. Color vision also changes as one becomes older. The lens tends to yellow which filters out the violet, blue and green colors. It is much easier for older people to see yellow, orange and red. Thus, for older people to get the same satisfaction from looking at colors in their surroundings that young people get, their environments should present more yellow, orange and red, and less violet, blue and green.

Hearing is another major sense that, when impaired, can have a major influence in an older person's life-style. Impaired hearing is a hearing loss of sufficient magnitude to reduce the individual's capacity for interacting successfully with his or her environment (Atchley, 1980). Impaired hearing appears to show a marked increase after the age of 45.

Other senses that play a role in the well-being of an older individual are those of taste, smell and touch. While it is true that these deal mostly with satisfaction, they can also be of significant importance

to survival. In order to detect spoiled food one relies on his sense of taste. The presence of smoke or gas fumes is detected by the sense of smell. The sense of touch which communicates our feelings of pain or discomfort, when impaired, can postpone one from seeking medical help and can threaten that person's well-being.

In recent years there has been a growing recognition of how these two previously mentioned aspects of aging play an important role in the third aspect of aging - that of the sociological aspect.

Socialization encompasses the group of processes that result in the development of the individual into a social being capable of participating in society (Atchley, 1980). The achievements one makes in the way of socialization usually comes from experience. Many decisions and changes occur in one's lifetime. By middle age one has achieved set roles in society. By old age, however, these roles may change significantly thru widowhood, retirement, etc. A big problem can arise out of attitudes society holds in regards to these changes. The elderly often tend to hold negative attitudes toward aging and toward life in general. It must be remembered that attitudes are learned.

These attitudes have in turn led to beliefs which have in turn led to stereotyping which appears to be ever so present in our society. The stereotype associated with old age in America is overtly negative and biased and this bias greatly affects how older people are treated by others in our society. The medical and allied health professions are no exception. To understand why, one must consider the past and future population growth and relate it to health care needs.

When the first census was taken in 1790, half the people in the country were sixteen years old or younger, and as recently as 1970 the median age was under 28. But as the nation moves into its third century, its people, too, are getting older. The median age will pass thirty in 1981, reach thirty-five by the year 2000 and approach 40 by 2030. It is also estimated that those over 65 will more than double to one out of every six Americans (Newsweek,1977).

Since the beginning of this century there has been a dramatic increase in the numbers of older people. In 1900 there were slightly more than three million in the United States, and in 1977 there were over twenty-three million - a sevenfold increase, double the increase for the general population (Atchley, 1980). The United Bureau of Census projects

that by the year 2030 there will be thirty-two million older Americans. (The term older American refers to those people 65 years of age and over). These figures may sound startling, howerer, what impact does it have on the health care field? One question that arises is whether the health care professions are ready to deal with this increase.

At the present time there are approximately five percent of our elderly population in some kind of long-term care institution such as nursing homes, retirement homes and mental hospitals. The total chance of an elder being institutionalized at some time before death has been estimated by two studies at about twenty-five percent (Palmore, 1976). It is generally agreed that many, if not a majority of present institutions are inadequate in their facilities, treatment and personnel. Most do little or nothing toward restorative services and provide littl more than custodial services while their patients await death (Palmore, 1976).

Though excellent care is provided in some of the facilities, the long-term care industry has been seriously criticized. Long-term care facilities are too often isolated from the more extensive back up services of hospitals, from community-based programs

and from major professional schools.

It is important to remember that the treatment of chronic conditions constitutes the major health care problem of the older population. Approximately 86 % of the population over age 65 have one or more chronic conditions; multiple chronic conditions are common among the elderly (Harris,1978). The medical profession focuses on diagnosis and treatment of acute illness and, for the most part, is uninterested in the care of chronic conditions which typify the health care needs of the elderly. Doctors and health professionals are not trained to deal with the unique medical problems of the elderly (Butler, 1977). The body of knowledge required to care for old people is not just disease categorical; it is broad in perspective. It deals with the people from a holistic point of view. The word "holistic" is an interplay of body and mind in the interest of producing a unified person. Holistic was derived from the Greek word "holos" which means "healthy", "entire", and "whole", it implies "being in the right relationship with self, others, and the universe" (Walker, 1979).

Those people employed in caring for the elderly must remember that they are not treating diseases - they are treating people - individuals with special

feelings, needs and fears. "A holistic definition of aging should communicate the idea that the changes associated with aging are normal and continuous, resulting in losses and gains. Negative images could be evoked from the term "losses," however, it must be remembered that the elderly often experience change so gradually that they develop successful coping skills and accept the change as a normal part of life." (Schrock, 1980).

As unbelievable as is may seem, geriatric medicine is not yet recognized as a medical specialty in the United States, although on the average, forty percent of an internist's patients are 65 years of age or older and he spends sixty percent of his time with them (Butler, 1976). The field of nursing, however, has begun to recognize the care of the elderly as a specialty. The nurse has been suggested to be the most appropriate and best prepared health care worker to assume major responsibility for health care of the elderly (Schwab, 1979). In 1974 the American Nurse's Association voted to change its "Division of Geriatric Nursing Practice" to the "Division of Gerontological Nursing Practice", reflecting a broader approach to the care of the aged. "Geriatric" refers to the branch of health care which deals with the problems and diseases

of aging and old people. "Gerontology" is a branch of knowledge dealing with aging and problems of aging (A.N.A., 1974). Thus "geriatric" was seen to be too much directed toward the sick aged, and the nurses wished to convey by their name that nursing care of the aged has to be approached in a holistic manner with more emphasis of the psycho-social and cultural aspects of the patient's experience, rather than a more strictly medical approach (Schwab,1979); thus one step forward to improving and recognizing the care needed by our elderly.

Butler in 1975 pointed out that one-third of a million professional and technical workers are employed in programs designed primarily or solely for older persons....fewer than 10-20% have had formal training for their work (Bradshaw,1980). Most educational programs that have anything to do with gerontology are usually taught at a Masters Level or higher. This is fine, but how are the people who are responsible for the direct patient care (aides, nurses, therapists, etc.) going to benefit from this type of educational arrangement? This was to be my challenge.

Based on the research and information already presented, it was apparent that the less educated a person is in the field of gerontology the less he

really knows about aging and the needs of the aged. The question in my mind was what I could do to educate the people involved in caring for the elderly in my community in order to improve the care given. It is my belief that the more one knows about something the better able he will be to deal with it. Health care professionals, I have found, lack the increased knowledge to deal effectively with the aged population.

III. IMPORTANCE OF THE PHYSICIAN

One can learn best the principles of geriatrics when guided by an experienced geriatrician. A geriatrician pays as much, perhaps more, attention to the techniques of care of chronic conditions as to the complexities of tertiary care for acute, severe illness (Cape, 1978). The medical problems presented by the elderly, such as the "geriatric quintet" (falling, confusion, incontinence, homeostatic disturbance, and iatrogenic disorders), require special skills and techniques from a geriatrician in practice (Cape, 1978).

The aged person has a multitude of problems in the later years. The aged are afflicted with chronic conditions such as heart disease, deafness, leading to disability and restriction of their activity. Although the aged generally have more than one illness the extreme variability in the health status of older people definitely shows that poor health is by no means necessarily associated with aging (Atchley, 1980). I chose Doctor Paul Biedenharn, a geriatrician, who is a consultant at numerous nursing homes with over ten years of experience in caring for the aged to be the team leader of my seminar. His initial training was

in family medicine; he then specialized in geriatrics. Since the elderly have impairement in mental health, lack of social support systems, deminished economic resources, and decreased capacity for self-care, there is a need for a multidimensional approach to data acquisition and patient assessment (Moore,1980). This team is best lead by a geriatrician because of his ability to coordiante the various specialties in order to render an organized care plan.

IV. RELATIONSHIP OF ACTIVITY AND MOVEMENT

A misconception associated with aging is that the older person should take it easy, however, there are numerous articles written on the benefits of exercising and aging. In the "Principles of Exercise Programs" written by Arnold (1977) there were ten benefits listed. They were:

1. Improvement to cardio-vascular function.
2. Development of muscle strength.
3. Development of endurnace.
4. Development of flexibility and joints.
5. Provision for relaxation and release of tension.
6. Delay of the aging process.
7. Development of coordination and to learn new skills.
8. Developments of an understanding of the role of exercise and physical activity.
9. Maintenance of good health.
10. Opportunity for social growth and development.

Besides the above benefits there are the social contact and psychological benefits of exercising. For this reason I felt that the health professionals caring for the aged should be made aware of the benefits of movement. A concept of "life satisfaction" is when people have aged successfully to the extent that they feel happy and satisfied with their present and past lives (Atchley, 1980). To feel happy a person must have an active life. Aging is an insidious, inevitable, and lethal entity that drains a persons body and spirit. The person sees it hears it and feels it

every day of his life (Kreisle, 1982). This is enhanced when a person is confined to a nursing home. Prior to the nursing home, the "activity" theory stresses that to age successfully, one must maintain into old age the activity patterns and values typical of middle age. Participation into a pool of assorted physical or mental gymnastics is done with utter abandonment of the aging process. The elderly person then becomes totally engulfed in an attempt to ward off the stigma of aging. Then there is the "disengagement" theory on aging which is just the opposite of the activity theory. One will find this more prevalent in a nursing home, especially if the staff is not trained in other aspects of the patient's needs. The patient looses his determination and the responsibility for his life becomes that of the staff. The patient develop a helplessness and hopelessness in a nursing home situation, which one psychiatrist classified as a "giving-up-given-up complex" (Benson, 1979).

Movement therapy or exercise can help the nursing home resident improve in the sociological, psychological, and biological phrases of aging. I a thesis by Sherman, five benefits were listed for movement therapy. They were:

1. By supplementing movement and sensory deficit, a psychological need is fulfilled.

2. By the physical safety of the movement and the psychological safety of the presentation, an ego need for security is fulfilled.
3. By promoting a feeling of group consciousness that grows out of a helping relationship, a feeling of belonging is fulfilled.
4. By promoting a congenial, supportive environment in which a group laughs easily at the same things, a participant changes his frame of reference from fatigue and depression to relaxation and exhilaration.
5. By acceptance and accommodation of each person's limitations, an atmosphere is created which facilitates the recognition of each person's unique achievements.

(Sherman, 1981).

V. RELATIONSHIP OF THE SOCIOLOGICAL ASPECT OF AGING

Although exercise is an important element in aging there is the social aspect that will have an influence on the nursing home resident. Such matters as previous social level, housing, and transportation will effect the residents stay in a facility. In 1973 the poor aged represented 14.6 percent of the total poor population, with 16.3 percent of persons age 65 or older receiving money income below the poverty standard for that year (Schulz, 1980). Another problem that faces the elderly is housing. Where a person lives largely determines his or her opportunities for contact with other people and their access to various community services. According to Atchley, 95 percent of older Americans live in independent households, and of this, 10 percent are headed by a person under 60 (Atchley, 1980). With the inflation era and higher taxes it is becoming more difficult for them to maintain their own home, and car. The low income household headed by the elderly has the lowest rates of car ownership then any other low income group in any age group (Golart, 1976). If special housing units are provided it is important to include a location with availability of public trans-

portation. It should also provide for access to shopping facilities, recreation, church and cultural centers so that the older person can remain active in the community (Estes, 1979). Other services to consider would be availability of grocery stores, banks, post office, doctor's office and restaurants. There is also an increasing demand for special housing to provide such services as the preparation and serving of meals, housekeeping and medical care (Regnier, 1976). An advantage of special housing units according to Blau is age segregration. This promotes the social opportunities of older people to gain access to others who have common social needs and common political interests (Blau, 1973). Poor housing planning could be detrimental to the elderly. It could, be inadequate in sturcture, lack a congenial environment, foster isolation, and result in inaccessibility to transportation and shopping (Blau, 1973).

Transportation is a major factor in aging. Transportation difficulties may represent the first concrete signs that a person is becoming old and will no longer be able to carry on his accustomed way of life. At every level, older persons have a considerable lower rate of automobile ownership than other age groups(Golart, 1976). There are also statistics that

that show a much lower proportion of persons over age 70 possessing a license as compared to the age group of 65 to 69 (Golart 1976). Due to the decreased automobile ownership, mass transit is important for social and recreational trips. In all studies done, the relative importance of the taxi is reported to be very small (Golart, 1976). Golart also stated that, on the average weekday, the elderly tend to make fewer vehicular trips per person than the total population. There is also a higher incidence of accidents among the elderly who drive.

Another social aspect of aging is friendship which is related to housing and transportation. Spakes has shown that the number of close friends in the community increases with the level of participation in social activities (Spakes, 1979). It was also noted that friends are relatively more important than families in the lives of a older person. If assistance is needed a friend would generally be called first. Another advantage of friendship in the later years is the psychological aspect of aging. People who belong to a friendship clique usually consider themselves old less often than those who do not participate in a friendship clique (Blau, 1973). Friends and family are considered as informal support systems verus a

formal support system. The formal support system consists of community services. Lebowitz suggested .at the informal support system is best able to handle the unpredictable, nontechnical diffuse tasks of living, whereas formal support systems are best able to handle the predictable, technical, and specific ones (Lebowitz, 1978).

A final sociological factor in aging is that housing, automobiles or lack of support, whether formal or informal, can lead to physical pathology. If no transportation is available the person must walk to get to his destination. Walking, however, can cause considerable fatigue, physical soreness, and general weakness (Blau, 1973). Of course these potential problems orginate partly as a result of physiological changes accompaning aging. There is a prevalence of physical pathologies among the low income, non-whites and less educated (Atchley, 1980).

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VI. REVIEW OF PERTINENT LITERATURE

A review of the literature starting with the investigation of Hickey and extending back to Coe, showed the importance of knowledge in caring for people. The physician's attitude is one of disease process, whereas the physical therapist and nurse are concerned with the social-psychological attitudes. The social workers tend to ignore physical disease and focus on socio-emotional and socio-cultural components of aging (Coe,1967). They all tend to have a negative attitude toward the aged, such as "aging is all down hill", and that"eventually everyone will deteriorate". Nurses have a generally negative attitude toward providing care for the aged patient as well as a perception of small reward (Coe,1967). This attitude is transmitted to other student nurses by fellow students and by instructors (Coe, 1967). The medical field has been lax in recognizing the aspects which compose the field of gerontology and has been responsible, in part, for inferior health care to our elderly population. These attitudes, however, must change, and education is the means of changing them.

I felt that if I could instill a more positive

attitude about aging, this would improve the quality of care. It has been shown that the less educated person has more misconceptions and is more biased against the aged (Palmore,1977). Palmore stated that training in gerontology improves the knowledge and test score on his quiz, "The Facts on Aging." He also stated that health professionals improve their knowledge with seminars on aging (Plamore,1977).

Such biased attitudes as "older persons take longer to learn" and "old people are set in their ways" are dispelling with additional education on aging. Through this seminar I hoped to enlighten the participants to biological and sociological aspects of caring for the aged. This would be accomplished through speakers with specialization in the medical, physical and social aspect of aging. Through case presentations, didactic lectures and movie and slide presentations, hopefully the knowledge would be transmitted from the lecturers to the participants. Using this method of presentation I hoped to instill a team approach to caring for the aged. Better care is rendered through team approach than individual specialization (Hutt, 1980). In rendering care to the aged no one health service discipline can provide all the knowledge and resources required. Professor Margaret Scott Wright, formerly

professor of nursing studies at the University of Edinburgh, believes in the multidisciplinary approach to the education of the health care team. She said "the input of the different professions involved varies considerably and often fluctuates during the provision of care for the individual client; Thus, the need for students of various professions to participate in some common learning processes in order to appreciate the specific contribution which can be made by each of them and to avoid wasteful overlap, is irrefutable" (Hutt, 1980). Hopefully, this seminar will give various insights to treating the aged by various disciplinaries. Scott Wright also stated that "little more than lip-service has been paid so far to multidisciplinary education" and argues that undoubtedly the reason for this has been the reluctance of the professions to put the patient or client into the middle of the arena rather than on the periphery (Hutt, 1980). Again by presenting a multidisciplinary seminar multiple veiw points on treating the elderly patient can be given to the participants. The elderly patient should not be seen as a collection of many diseases but as a person whose capacity for functioning as a human being can be diminished by active or potential disabilities. The prime concern of the multidisplinary

approach is a restoration of the patient's maximum functional status.

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VII. METHOD

Various speakers were chosen for their background training and knowledge of the geriatric population. Doctor Biedenharn, as previously mentioned would be the geriatrician, and would deal with the role of the doctor as a coordinator of health services to the elderly.

Doctor Ann Carey, a speech-language pathologist, is a full time university instructor, and does consultant work to area nursing homes. She had also participated in numerous seminars on aging. Since speech therapists deal with different forms of communication disabilitities, ranging from patients with vision and hearing problems to those suffering from aphasia and dysphasia, all problems which affect our elderly population, I felt as though the information concerning these problems would prove invaluable to a group of allied health professionals.

The nursing aspect would be covered by a registered nurse, Sandra Gain, who has over ten years of experience working with the geriatric population. She also a certified gerontological nurse which makes her a specialist in the medical care of the elderly.

Since a significant part of the aging process

concerns itself with the sociological aspect of aging, a social worker with a thorough knowledge was chosen. Margaret Wayne, a former St. Louis University instructor, and presently the Director of Social Services at Memorial Hospital in Belleville agreed to speak. She would speak on social problems of the elderly.

Donald Courtial, Director of Physical Therapy Services at Memorial Hospital in Belleville, was to speak on "A Holistic Approach to Treating the Elderly". Mr. Courtial has given numerous seminars and workshops on the holistic approach to treating health problems.

My portion of the seminar would deal with the conventional physical therapy treatment of the elderly. My past experience as a consultant to various nursing homes for six years made me more aware of the geriatric patient. Giving inservices to these homes on the special needs of the residents and means of treating their's problems was on of my responsibilities.

In planning for the seminar a decision has to be made on what date to hold the seminar. From past experience as an attendee, meetings at the end of the week were more enjoyable and better attended. A tentative time schedule was developed, starting at 8:00 A.M. and finishing at 4:00 P.M.. The rationale for this time was to make the seminar relaxed and non-stressful. Starting too early would force some

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participants to rise earlier in the morning than usual. Too long of a meeting would lose the attention of the participants. A proposed program listing the speakers and a tentative time schedule was prepared (Appendix A). The location of the seminar was picked for the convenience of the majority of attendees. Since the anticipated attendence would be from a 20 - 40 mile radius, the Shrine of Our Lady of the Snows was chosen. It is well known and located on a highway with good facilities for meetings. They have a restaurant, gift shop and beautiful landscaping for short walks if so desired by the participants.

I set deadlines for the thing that still had to to be accomplished. The following deadlines were established:

June 12th - the meeting room and luncheon were to be confirmed

June 13th - have pamphlets to the printer

July 20th - have pamphlets mailed

Aug. 1st - open checking account

Aug. 14th - deadline for pre-registration

Aug. 24th - turn in project to Lindenwood

It was a task to check on continuing education units, pamphlets, name tags, stamps, folders, checking account, meals, meeting room, coffee breaks, pens and

writing pads. However, I did set deadlines for particular responsibilities to ensure a thoughtful and well organized seminar.

I made contact with Our Lady of the Snows, reserved the date for the meeting, and obtained a cost for meals, coffee breaks, and room. A hot luncheon buffet which would consist of three meats, two potatoes, six salads, bread, choice of beverage and gratuities would run $6.50 per person for 100 or more people. The charge would be $7.50 per person for less than 100 people. Tax was not included in the cost. Coffee breaks would cost fifty cents per person per break. The room would cost nothing provided I had twenty-five people or more attending the seminar. At this time I was estimating 100 participants for the seminar. I was able to acquire free writing pens for the seminar through a medical supply house in Belleville. I was trying to keep the cost low for this seminar so that a large number of people would respond. Writing pads were donated by a medical company in Missouri.

The mail-out pamphlets were my next primary concern. I considered the possibility of having a picture of an elderly person on the cover of the pamphlet. I spent the next week looking for an acceptable picture, and was to obtain backgound information on the speakers. A list of all nursing homes, colleges, and hospitals in

the metro-east area was secured (Appendix B). This was to be the mailing list.

On June 13th I had a budget prepared to help decide the cost of the seminar (Appendix C). I estimated a cost of $15.00 pre-registration and $20.00 on the day of the seminar. This was to cover expenses including the meals and honorariums. There still was a need to decide what the pamphlet would contain, background on speakers and the objectives of the seminar.

On June 25th, I had laid the format of the seminar. I had decided against a picture due to the problem with copying. The format was as follows:

"A Multidisciplinary Approach to Aging"

August 28, 1981

(Friday)

at the

Shrine of Our Lady of the Snows

Visitor's Center

Route 15

Belleville, Illinois

62223

Sponsored by: The Lindenwood Colleges, St. Charles, Mo.

and

Oscar R. Gain, Jr., B.S., R.P.T.

and

Sandra K. Gain, R.N.C., B.S.

ST. CHARLES, MISSOURI 63301

Purpose: The purpose of this seminar is to provide in lecture and panel discussions, a comprehensive program on problems encountered with geriatric patients and methods of dealing with them. It is designed to increase the knowledge and enhance the skill of the participants. The guest lecturers include a geriatrician, certified gerontological nurse, speech therapist, physical therapists, and social worker.

Objectives of the course are;

1. To increase general knowledge of the geriatric patient
2. To sensitize the allied health professional to the needs of the elderly
3. To stress the importance of team work
4. To improve knowledge and skill in assessing the health needs of the elderly
5. To improve care of the elderly now and in the future

This program is designed for personnel employed in the care of the geriatric population.

I typed out a rough draft of the pamphlet to get a general idea fo the lay-out and to see how the mail out pamphlet would look (Appendix D).

I had a meeting with my faculty advisor on July 8, 1981 and discussed the upcoming seminar. A sample

program was given to her to read and approve. The faculty advisor was to obtain approval from Lindenwood for the program and feasibility of continuing education units. She suggested some changes on the final pamphlet, one which included a box to check for continuing education units.

The faculty advisor obtained approval for the program and told me about the additional cost. The additional cost forced me to increase the fee to $20.00 to cover expenses. I was reluctant to do this, fearing a lower response for the seminar. There would be an initial fee of $25.00 to Lindenwood plus $5.00 for each participant desiring credits from Lindenwood.

The final version of the phamphlet was typed. It turned out better than I had expected. It turned out so well, in fact, that I tried to xerox it. It copied well, so I decided to print my own copies. I was not pleased with the white xerox paper, however. I thought that if facilities posted this on a bulletin board, it would not stand out enough among all the various pieces of paper so often found on bulletin boards. I went out and purchased a package of bright yellow paper. (Bright yellow also being symbolic as to one of the colors most easily seen by the elderly. Whether anyone ties in this symbolism,

ST. CHARLES, MISSOURI 63301

I guess is really besides the point.) I tried xeroxing the program onto the yellow paper and was very pleased with the results (Appendix E). I ran off 100 copies and folded and stapled them the same night. the next day I purchased some self-adhesive address labels. I typed the address labels from the list of local facilities which I had secured previously, applied stamps, and had them in the mail by August 1, 1981. These copies were sent to nursing homes with in a fifty mile radius and local hospitals. The total number of pamphlets sent out was seventy-three. I expected approximately one to two people per nursing home and possibly one person per hospital. A deadline of August 18th was set for registration forms to be returned in order to help plan on needs for the seminar.

During this time, I was also working on the requirements for the Illinois Nurses' Association continuing education units. I typed up all the necessary papers, including an evaluation form which was required, and mailed all of this along with a check for $25.00 to the Illinois nurses' Association (Appendix F). I had requested six contact hours of credit. The criteria of Illinois Nurses Association for continuing education units was followed (Appendix G).

The Illinois Nurses' Association requires that the sponsoring agency provide each participant, who requests continuing education units, with a certificate of completion. This required more planning and considerations. Since I knew that Lindenwood could not be responsible for providing this, I began shopping around for something that could serve the purpose. Several stores did sell blank certificates, which could be filled in by a sponsoring agency, however, the cost of these was unbelievable. I realized that I had to find another alternative.

I decided to experiment with one of my old certificates that I had received at a previous seminar. I blocked out everything but the border and ran a xerox copy of this. It turned out pretty well (Appendix H). Now all I had to do was to type it up in agreement with the Illinois Nurses' Association requirements. I used three different types of print to give it a more professional appearance. I was pleased with the results. I decided to run xerox copies of this, which I would give out to the participants upon completion of the seminar (Appendix I).

Since most of the major components of the seminar had been completed I now had to give some serious thought to my own presentation. My program was

developed to emphasize the need for other facilities to promote physical exercise for the geriatric person. Slides were made of basic equipment that was necessary to improve mobility and optional equipment available. A new acronym was developed by me to assist in the evaluation of residents (Appendix J).

I was now awaiting the date of the seminar. Final preparations of slides and audio-visual equipment requirements were being made. An evaluation form was developed, following the guidelines of the Illinois Nurses' Association for continuing education units (Appendix K). I typed out the test and ran copies of it so one could be included in each folder. I ran copies of the research and documentation aspect of the quiz to give to each speaker. I figured that if there would be a lull in the panel discussion, we could discuss this information at this time. (It could also be used to fill in the time, should a speaker have to cancel (Appendix L). I felt as though I should include a bibliography in everyone's folder, in case they would like further knowledge in any of the areas (Appendix M).

I contacted my faculty advisor and confirmed the date, time and place of the seminar. She stated that she would be there for part of the program if not for the entire presentation. The written work done up to

this time was given to our faculty sponsor. She would not be able to attend the seminar due to her job committment.

Continuing education units had been awarded by the Illinois Nurses' Association and the biennial approval number that had been assigned to our program had to be added to the Certificates of Completion.

I decided that the certificates would look much neater if the participants name was typed on the certificate rather than hand-written. This was done on the evening of the 25th.

Knowing that the registration period of the seminar would be rather hectic, I asked a friend of mine, to sit at the registration table. She woùld be in charge of collecting for late registration and would see that each participant received a name tag and folder. In turn I would provide her with a free meal and the opportunity to take advantage of the seminar at no cost.

By Thursday, the day before the seminar, I had received a total of twenty-seven paid registrations and four telephone registrations. Things were beginning to look more promising. Throughout the entire pre-registration period I tried to keep tract as to which registrations were paid by facilities and which were self-payed. I also tried to keep a record as to the

various facilities that would be represented.

Following the seminar, I will analyze the outcome of the seminar in respect to success or fãilure, reasons for this, and possible soulutions to any problems that developed.

VIII. DAY OF THE SEMINAR

I had made plans to be at the Shrine by 6:30 A.M.. I had done a rather thorough job of getting everything together the night before, therefore, the confusion and last minue jobs were pretty well eliminated. I took along two extension cords in case the cords to the projectors did not reach to the outlets.

I arrived at the Shrine at approximately 6:30 A.M.. The chairs and movie screen had already been set up. There was only a minimal amount of rearranging that had to be done. The registrants began coming around 7:30 A.M.. As more people filled the room, the more nervous I became.

The gerontological nurse did the introduction of each speaker.

The first speaker was Doctor Paul Biedenharn. He presented case studies and had the audience participate by asking various questions. This was well received by the audience.

The next speaker was the gerontological nurse. She lectured on the role of a nurse in long term care and the importance of communication between the doctor and the nurse. She developed a nursing assessment form

10330

and explained the reasoning and purpose of the form. A slide presentation, accompanied by a poem, ended her lecture with the audience being emotionally touched by the poem and slide presentation (Appendix N).

My presentation consisted of slides with an explanation on the purpose and need of certain types of physical therapy equipment in long term care facilities. The last part of my lecture consisted of a physical therapist's assessment tool, developed by me, for assessing patients functional abilities (Appendix O).

The next speaker was Dr. Carey, the speech pathologist. She presented a slide and video tape on communication needs. Numerous hand outs were given to the audience with special glasses being adorn to simulate hemianopsia. Various devices used by laryngectomies were demostrated by Dr. Carey. She was well received by the entire audience.

Lunch was provided and each speaker sat at separate tables to encourage questions about the presentation. The responses at lunch were positive up to that time.

Donald Courtial spoke on the holistic approach to caring for the elderly. I knew he was a dynamic

speaker and decided that he would be more effective after lunch. Don stressed preventive care. He, too, was well received by the audience.

My final speaker was Margaret Wayne, a social worker. She related the similarity of Don's presentation to that of social workers. The idea of building up the patient's strong points and not dwelling on their illnesses was stressed. Her presentation was in lecture form and covered some of the different services available to the elderly in the community. Margaret had an average reception. This could have been due to her speaking last. I was not sure of Margaret's speaking ability in front of a group. If I decide to conduct another seminar the last speaker would be a more dynamic speaker.

IX. DISCUSSION

I had 28 pre-registered participants, 4 phone-ins and 2 on-site for a total of 34 participants (Appendix P). There were 8 professions represented at the seminar. Of this group 56% were registered nurses, 18% licensed practical nurses, 8 % physical therapist assistants, 6% physical therapist aides and the remaining attendees accounted for 3%.

There were 15 different facilities represented, 14 long-term care and 1 hospital. This was approximately 21% response to the total announcements sent to facilities. The average attendee per facility was 2.2. Twenty-four percent were self paid and 76% were paid by the facility. Thirty-three requested CEUs from the Illinois Nurses' Association and one from Lindenwood.

There was 88% return on the evaluation forms. The ratings, in general, were outstanding (Appendix Q). The response to questions 1 thru 5 were favorable with only 3 stating that question 1 was not helpful, 1 on question 4 and 2 on question 5.

Financially, the seminar was a success, since the ending balance was a credit (Appendix R). This is due, in part, to Dr. Biedenharn returning his honorarium.

X. CONCLUSION

I felt that the seminar was successful. I had excellent attendance both in the a.m. and p.m.. At the end of the seminar there were still 32 participants present. The evaluation forms rated the individual speakers with outstanding approximately 50% of the time with the exception of Margaret Wayne. He low rating could have been due to two factors. The first one was that she was the last speaker of the day. The other possible factor was that she had only one social worder in the audience.

Financially, I managed to be in the black. This was due to three factors. One reason was the return of the honorarium by Dr. Biedenharn. The other reason was that I developed my own forms rather than having a printer do the work. The final reason was that my place of employment furnished me with a copier, and paper.

If another seminar is given I would probably increase my charge by $10.00 to cover my time and the time for a secretary. I would also obtain a mailing list from the different discipline associations and send them announcements. I am sure I would have had a larger group if I would have done this for the

seminar.

There were no registered physical therapists at the seminar with the exception of myself and the other speaker, Don Courtial. A possible cause for this was that the pamphlets were not circulated among the physical therapy departments in the area. Also, a mailing was not sent to the physical therapists in Southern Illinois and St. Louis. I was surprised that only one nurse's aide attended the seminar. Maybe the pamphlet could have listed the disciplines that would have benefited from the seminar. Nurse's aides are a member of the team, too, and could have learned from this seminar. Another change would be a work shop like approach in the afternoon session of the seminar or possible a two-day seminar with afternoon workshops.

I felt that this was an excellent learning experience. From the response of the attendees I am going to plan another seminar in the future with some changes in the format as mentioned earlier. I feel that the participants left with an increased awareness of the elderly. The care of the elderly might also be slightly better due to my small effort. If only one elderly person obtains better care, the time, effort and cost of this seminar woud be justified.

APPENDIX A

PROGRAM

Registration	7:45 - 8:30
Introduction	8:30 - 8:45
"The Role of the Doctor in Care to the Elderly" Dr. P. Biedenharn	8:45 - 9:30
"Nursing Assessment of the Elderly"	9:30 - 10:15
Break	10:15 - 10:30
"Conventional P.T. Approach to Treating the Geriatric Patient" Oscar Gain Jr.	10:30 - 11:15
"Communication Disorders in the Elderly" Dr. Ann Carey	11:15 - 12:00
Lunch	12:00 - 1:00
"A Holistic Approach to Treating the Elderly" Donald C. Courtial	1:00 - 2:00
Margaret Wayne	2:00 - 2:45
Panel Discussion	2:45 - 3:15
Adjourn	3:15

APPENDIX B

EXTENDED CARE FACILITIES

Anna-Henry Nursing Home
637 Hillsboro Avenue
Edwardsville, IL 62025

Blu Fountain Manor
1623 W. Delmar
Godfrey, IL 62035

Bohannon Nursing Home
1201 North Alton
Lebanon, IL 62254

Breese Nursing Home
1155 North 1st
Breese, IL 62230

Briarcliff Nursing Home
3354 Jerome Lane
Cahokia, IL 62206

Calvin Johnson
727 North 17th St.
Belleville, IL 62221

Cantebury Manor
718 North Market
Waterloo, IL 62298

Carlyle Healthcare Center, Inc.
501 Clinton
Carlyle, IL 62231

Castle Haven Nursing Center
225 Castellano Drive
Belleville, IL 62221

Chastain's of Highland, Inc.
2510 Lemon St. Rd.
Highland, IL

Clinton Manor
111 E. Illinois St.
New Baden, IL 62265

Colonnades Nursing Home
#1 Colonial Drive
Granite City, IL 62240

Colonial Haven Nursing Home
3900 Stearns Avenue
Granite City, IL 62040

Dammert Geriatric Center
9500 Rt. 460
Belleville, IL 62223

D'Adrian Convalescent Center
1318 West Delmar
Godfrey, IL 62035

Eden Village Care Center
400 South Station Rd.
Edwardsville, IL 62025

Edwardsville Care Center
1095 University Drive
Edwardsville, IL 62025

Eldercare of Alton
3523 Wickenhauser
Alton, IL 62202

Eunice C. Smith Home
1251 College Avenue
Alton, IL 62002

Fair Acres Nursing Home
514 East Jackson
DuQuoin, IL 62832

Four Fountains Convalescent Center
101 South Belt West
Belleville, IL 62221

Freeburg Care Center
Route 2, Box 180M
Freeburg, IL 62243

Friendship Manor
305 Friendship Drive
Nashville, IL 62263

Friendship Villa Nursing Home
900 Royal Heights Road
Belleville, IL 62223

Grange Nursing Home, Inc.
901 North 10th St.
Mascoutah, IL 62258

Heidelberg Retirement Home
200 Abend Street
Belleville, IL 62221

Highland Manor
27th Street
Highland, IL 62249

Hillview Manor
4th St. Spur, Rt. 3, Box 207
Greenville, IL 62246

Lincoln Home
150 North 27th St.
Belleville, IL 62221

Madison County Nursing Home
2121 Troy Road
Edwardsville, IL 62025

Mar-Ka Nursing Home
201 South 10th St.
Mascoutah, IL 62258

Maryville Colonial Manor
I 70 & Rt 159
Maryville, IL 62062

Memorial Convalescent Center
4315 North Park Drive
Belleville, IL 62223

Meredith Memorial Home
16 South Illinois
Belleville, IL 62221

MillHaven Care Center
415 Veteran's Drive
Millstadt, IL 62260

Monroe County Nursing Home
500 Illinois Avenue
Waterloo, IL 62298

New Athens Home
203 South Johnson
New Athens, IL 62264

Notre Dame Hills
6401 West Main Street
Belleville, IL 62223

Park Haven Care Center
Box 355, 107 South Lincoln
Smithton, IL 62285

Parkview Colonial Manor
300 Weber Road
O'Fallon, IL 62269

Perry Manor, Inc.
708 Virginia Ct.
Pinckneyville, IL 62274

Pinckneyville Community Hospital, SNF
101 North Walnut
Pinckneyville, IL 62274

Pleasant Rest Nursing Home
614 North Summit Avenue
Collinsville, IL 62234

Professional Care, Inc.
200 East Taylor St.
Troy, IL 62294

Randolph County Nursing Home
310 West Belmont
Sparta, IL 62286

Red Bud Nursing Home
350 West South 1st Street
Red Bud, IL 62278

Senior Manor Nursing Center
223 East 4th Street
Sparta, IL 62286

Styrest Nursing Home
120 North Tower Road
Carbondale, IL 62901

St. Ann's Healthcare Center
770 State St.
Chester, IL 62233

St. Paul's Home for the Aged
1021 West "E" Street
Belleville, IL 62221

VIP Manor
393 Edwardsville Road
Wood River, IL 62095

Warren G. Murray
1717 West Broadway
Centralia, IL 62801

Weier Retirement & Nursing Home
5 Gundlach Place
Belleville, IL 62221

West Main Nursing Home
1244 West Main
Mascoutah, IL 62258

AREA HOSPITALS

CLINTON COUNTY:

St. Joseph's Clinton County Hsp.
Jamestown Road
Breese, IL 62230

St. Mary's Hospital
400 No. Pleasant Avenue
Centralia, IL 62801

MADISON COUNTY:

Alton Memorial Hospital
Memorial Drive
Alton, IL 62002

Alton Mental Health Center
4500 College Avenue
Alton, IL 62002

St. Anthony's Hospital
Saint Anthony's Way
Alton, IL 62002

St. Joseph's Hospital
915 East Fifth St.
Alton, IL 62002

St. Elizabeth's Hospital
21100 Madison Avenue
Granite City, IL 62040

St. Joseph's Hospital
1515 Main St.
Highland, IL 62249

Oliver C. Anderson Hospital
Rte. 162 & Old Edwardsville Road
Maryville, IL 62062

Woodriver Township Hospital
Edwardsville Road
Woodriver, IL 62095

RANDOLPH COUNTY:

St. Clement's Hospital
325 Spring Street
Red Bud, IL 62278

Sparta Community Hospital
818 East Broadway St.
Sparta, IL 62286

ST. CLAIR COUNTY:

Memorial Hospital
4501 North Park Drive
Belleville, IL 62223

St. Elizabeth's Hospital
211 South Third St.
Belleville, IL 62221

Centreville Township Hospital
5900 Bond Avenue
E. St. Louis, IL 62207

Community Hospital
1509 Martin Luther King Drive
E. St. Louis, IL 62201

U.S. Air Force Medical Center
Scott Air Force Base, IL 62225

AREA COLLEGES

Belleville Area College
2500 Carlyle Road
Belleville, IL 62221

Kaskaskia Jr. College
Shattuc Road
Centralia, IL 62801

Southern Illinois University
Edwardsville, IL 62026

Office of Continuing Education - Box 84

APPENDIX C

BUDGET

	INCOME	EXPENSE
100 Participants @ $15.00 per person	$1500	
100 Meals @ $6.50 per meal		$ 650
Honorarium: Dr. Biedenharn		50
Dr. Carey		50
Margaret Wayne		25
Donald Courtial		25
Stamps:		18
Coffee breaks @ $6.50 per person for two breaks		100
Secretarial: 10 hours @ $8.00 per hour		80
Miscellaneous:		100
TOTALS: (7-06-81)	$1500	$1098

REVISED BUDGET AS OF 7-13-81

	INCOME	EXPENSE
Lindenwood College CEU 50 participants @ $5.00		250
Registration Fee with Lindenwood		25
100 participants @ $20.00 per person	2000	
TOTALS: (7-13-81)	$2000	$1373

APPENDIX D

A MULTIDISCIPLINARY

APPROACH TO

AGING

August 28, 1981

(Friday)

at the

SHRINE OF OUR LADY OF THE SN

Visitors Center

Route 15

Belleville, Illinois
62223

(618) 397-6700
or
(618) 235-2639

Sponsored by:

The Lindenwood Colleges
St. Charles, Missouri

Oscar R. Cain, BS, RPT

Sandra K. Cain, RNC, BS

A MULTIDISCIPLINARY APPROACH TO AGING
August 28, 1981

PURPOSE

The elderly are being cared for by professionals in all disciplines, often without the benefit of the increasing body of knowledge of their special needs. This program is an opportunity to learn from those who have specialized in the care of their medical and social problems. Through lecture and panel discussions, a comprehensive program will be presented to increase the knowledge and enhance the skill of the participants. The guest lecturers include a geriatrician, certified gerontological nurse, speech therapist, physical therapists, and a social worker.

OBJECTIVES

The objectives of this program are:

1. to increase general knowledge of the geriatric patient
2. To sensitize the allied health professional to the needs of the elderly.
3. To stress the importance of team work.
4. To improve knowledge and skill in assessing the health needs of the elderly.
5. To improve care of the elderly now and in the future.

PROGRAM

7:45-8:30	Registration
8:30-8:45	Introduction
8:45-9:30	The Role of the M.D. in Care to the Elderly Dr. Paul J. Biedenharn
9:30-10:15	Nursing Assessment of the Elderly Sandra K. Gain, R.N.C..
10:15-10:30	Break
10:30-11:15	Conventional P.T. Approach to Treating the Geriatric Patient Oscar R. Gain, Jr. Bs, RPT
11:15-12:00	Communication Problems in the Elderly Dr. Ann Carey,
12:00-1:00	Lunch (included in registration fee)
1:00-2:00	A Holistic Approach to Treating the Elderly Don Courtial, BS,RPT
2:00-2:45	Social Problems of the Elderly Margaret Wayne, MSW
2:45-3:15	Panel Discussion
3:15	Adjournment

REGISTRATION BLANK
" A Multidisciplinary Approach to Aging"
August 28, 1981

NAME ______________________

ADDRESS ______________________

CITY __________ STATE __________ ZIP CODE __________

HOME PHONE(___) __________ BUSINESS PHONE (___) __________

Pre-Registration Fee $15.00 (Form must be returned by Aug. 14, 1981)

Registration at the Door $20.00

Make check payable to __________ . Return this form and a check for $15.00 to Oscar and Sandra Gain, 1105 Forest Hills, Belleville, Illinois 62221.

APPENDIX E

LECTURERS

Paul J. Biedenharn, M.D., specialist in geriatrics

Margaret Wayne, M.S.W., social worker
Director of Social Services
Memorial Hospital
Belleville, Illinois

Ann Carey, Ph.D., speech-language pathologist and audiologist
Professor of Speech Pathology and Audiology
Southern Illinois University
Edwardsville, Illinois

Don Courtial, B.S., R.P.T.
Director of Physical Therapy Services
Memorial Hospital
Belleville, Illinois

Sandra K. Gain, R.N.C., B.S.
Certified Gerontological Nurse

Oscar R. Gain, Jr., B.S., R.P.T.
Assistant Director of Physical Therapy Services
Memorial Hospital
Belleville, Illinois

A MULTIDISCIPLINARY

APPROACH TO AGING

August 28, 1981
(Friday)

at the

SHRINE OF OUR LADY OF THE SNOWS

Visitor's Center

Route 15

Belleville, Illinois
62223

(618) 397-6700
or
(618) 235-2639

Sponsored by:

The Lindenwood Colleges
St. Charles, Missouri
and
Oscar R. Gain, Jr., B.S., R.P.T.
and
Sandra K. Gain, R.N.C., B.S.

REGISTRATION BLANK
"A Multidisciplinary Approach to Aging"

NAME ______________________ TITLE or POSITION ______________________

ADDRESS ______________________ CITY ______________ STATE ________

BUSINESS ADDRESS ____

HOME PHONE (____) ______________ BUSINESS PHONE (____) ______________

Pre-Registration Fee $20.00 (Form must be returned by August 18, 1981)

Registration at the Door $25.00 Please check one:

CEU's requested from INA ____

CEU's requested from Lindenwood ____

Make check payable to "Seminar on Aging". Return this form and a check for $20.00 to "Seminar on Aging", C/O Oscar and Sandra Gain, 1105 Forest Hills, Belleville, Illinois 62221.

A MULTIDISCIPLINARY APPROACH TO AGING

August 28, 1981

PURPOSE:

The elderly are being cared for by professionals in all disciplines, often without the benefit of the increasing body of knowledge of their special needs. This program is an opportunity to learn from those who have specialized in the care of their medical and social problems. Through lecture and panel discussions, a comprehensive program will be presented to increase the knowledge and enhance the skill of the participants. The guest lecturers include a geriatrician, certified gerontological nurse, speech-language pathologist, physical therapists, and a social worker.

OBJECTIVES:

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3. To stress the importance of team work.
4. To improve knowledge and skill in assessing the health needs of the elderly.
5. To improve care of the elderly now and in the future.

COST:

Pre-Registration	$20.00
Registration at the Door	$25.00

PROGRAM:

Time	Session
7:45-8:30	Registration
8:30-8:45	Introduction Sandra K, Gain, R.N.C.
8:45-9:30	"The Role of the M.D. in Care to the Elderly" Paul J. Biedenharn, M.D.
9:30-10:15	"Nursing Assessment of the Elderly" Sandra K. Gain, R.N.C.
10:15-10:30	Break
10:30-11:15	"Conventional Physical Therapy Approaches to Treating the Geriatric Patient" Oscar R. Gain, Jr., R.P.T.
11:15-12:00	"Communication Problems of the Elderly" Ann Carey, Ph.D.
12:00-1:00	Lunch (included in the registration fee)
1:00- 2:00	"A Holistic Approach to Treating the Elderly" Don Courtial, R.P.T.
2:00-2:45	"Social Problems of the Elderly" Margaret Wayne, M.S.W.
2:45-3:15	Panel Discussion

CEU's have been applied for through The Lindenwood Colleges and INA.

APPENDIX F

illinois nurses' association

6 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60602 • (312) 236-9708

SPONSOR APPROVAL FORM REQUEST TO AWARD CONTACT HOURS

Sponsoring Agency: The Lindenwood Colleges
(Name)

St. Charles, Missouri 63301
(Street) (City) (Zip Code)

Coordinator: Dr. Arlene Taich
(Name)

Faculty Administrator — Gerontology — 1-314-946-6912 Ext. 22-
(Title) (Department) (A/C - Phone)

Title of Educational Offering: A Multidisciplinary Approach to Aging

Number of Contact Hours Requested: 6

Dates Offered: August 28, 1981 Hours: 8:30 to 3:15

Will offering be repeated? Yes___ No x Repeated dates________

Fee Charged? Yes x No___ INA Member ____ Non-Member x

Please note: We will publish a notice of approved offerings in CHART, INA's official membership magazine, if deadline and space considerations permit. Please check here ___ if you do not want such a notice printed.

PLEASE ATTACH THE FOLLOWING INFORMATION (SEE ACCOMPANYING CRITERIA)

1. Description of Intended Audience
2. Nurse Involvement
3. Objectives of Educational Offering
4. Content of Educational Offering
5. Instructors' Qualifications
6. Evaluation Tool

FORM 7904
5/79
MHG/bw

LINDENWOOD COLLEGE LIBRARY

July 13, 1981

Oscar and Sandy Gain have permission to use the Lindenwood Colleges sponsorship for Continuing Education Gerontological Nursing to be held August 28, 1981, in Belleville, Illinois.

Applicants, Oscar and Sandy Gain agree to pay $25.00 to the Lindenwood Colleges for the sponsorship of the Continuing Education session on Geratric Nursing.

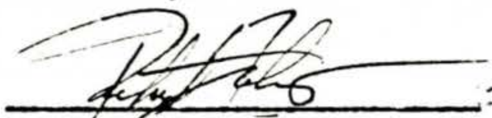
An additional $5.00 per student will be charged for those students indicating intent to request .5 Lindenwood College C.E.U.'s which must be paid by September 10, 1981.

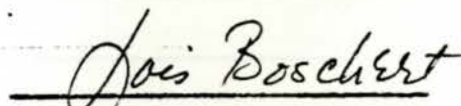
For those students who at the time of application, waive access to the .5 C.E.U. hours, no records will be kept by the Lindenwood Colleges.

It is advisable to assess any cost that the Illinois Nursing Association may wish to charge for the matriculation of their C.E.U.'s The Lindenwood Colleges cannot be responsible for any costs incurred by your program.

As Director of Continuing Educational Services, it is a pleasure to sponsor a program of such merit. Good luck with your enrollment.

Authorized by:





President
Lindenwood College

Director, Continuing
Educational Services

Applicants

Date

SAMPLE VITA SHEET FOR INSTRUCTORS

NAME ____
(Last) (First) (Middle)

ADDRESS ____
(Number) (Street)

____
(City) (State) (Zip)

EMPLOYER ____

____
(Number) (Street)

____
(City) (State) (Zip)

EDUCATIONAL DATA: Institution Major Year

Basic Preparation _________________________________

Highest Degree Held _______________________________

PREVIOUS EXPERIENCE, INTEREST OR EXPERTISE IN RELATION TO THIS EDUCATIONAL OFFERING:

____

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Please give a brief description of material to be presented:

LINDENWOOD COLLEGE LIBRARY

SAMPLE VITA SHEET FOR INSTRUCTORS

NAME GAIN SANDRA K.
(Last) (First) (Middle)

ADDRESS 1105 Forest Hills
(Number) (Street)
Belleville, IL 62221
(City) (State) (Zip)

EMPLOYER Four Fountains Convalescent Center
101 South Belt West
(Number) (Street)
Belleville, IL 62221
(City) (State) (Zip)

EDUCATIONAL DATA: Institution Major Year

Basic Preparation Belleville Area College - Nursing - 1972 -AD

Highest Degree Held College of St. Francis - Health Arts 1980 - BS

PREVIOUS EXPERIENCE, INTEREST OR EXPERTISE IN RELATION TO THIS EDUCATIONAL OFFERING:

1. Employed in long-term care for nine years.
2. Became nationally certified as a gerontological nurse thru ANA in 1979.
3. Have attended numerous seminars on geriatrics including a 5-day International Conference on Aging in Florida.
4. Presently completing work on a Masters Degree in Gerontology thru Lindenwood College in St. Charles, Missouri.

Please give a brief description of material to be presented:

Care of the elderly produces numerous challenges to the nursing profession. Often these nurses lack a knowledge base to guide their assessments and management in treating these people effectively. In this seminar I hope to present the 5-step model of the scientific process of problem solving which includes: 1) information gathering, 2) interpretation of the data, 3) nursing care planning, 4) implementation of the plan, and 5) evaluation of the care. I will then elaborate on the principles and methods involved of doing a thorough nursing assessment of the elderly patient. This will include and stress the importance of a thorough history including input from other health care disciplines. The importance of team work will be stressed. I will conclude the presentation with a short slide presentation which will stress the importance of "individualism" among our geriatric population.

A pre-test on myths and realities of aging will be given during the opening introduction to allow each participant to recognize their own misconceptions about aging.

SAMPLE VITA SHEET FOR INSTRUCTORS

NAME CAREY ANN LEE
(Last) (First) (Middle)

ADDRESS #33 Estates View Drive
(Number) (Street)

Fairview Hts, IL 62208
(City) (State) (Zip)

EMPLOYER Southern Illinois University

Department of Speech Pathology & Audiology
(Number) (Street)

Edwardsville, IL 62025
(City) (State) (Zip)

EDUCATIONAL DATA: Institution Major Year

Basic Preparation St. Louis University - Speech Path & Audio 1950 -BS

Highest Degree Held SIU Carbondale - Speech Path & Audio 1950 - MS
SIU - Carbondale - Speech Path & Audio 1969 Ph.D

PREVIOUS EXPERIENCE, INTEREST OR EXPERTISE IN RELATION TO THIS EDUCATIONAL OFFERING:

1. Consultant in communication problems of elderly hospitals and long-term convalescent centers, 1959 to present.

2. Professor - graduate course - SPPA 515-4. Communication problems of geriatric population Southern Illinois University - Edwardsville, IL.

3. Instructor - series of regional workshops on communication problems of elderly sponsored by the American Speech and Hearing Association - 1979-1980.

4. Examples of recent workshops on communication

Please give a brief description of material to be presented:

(Experience continued) of elderly include:

Chicago, May, 1979 — Speaker and/or
Mt. Vernon, May, 1980 — Director of each.
Chicago, April, 1980

(Description of material to be presented)

1. A slide/tape presentation developed with the help of grant from HEW - and developed by the American Speech & Hearing Assoc. will be utilized to introduce participants to nature of communication problems among elderly - these communication problems will be emphasized: a) aphasia, b) hearing impairment, and c) laryngectomees (removal of larynx).
2. Practical suggestions will be given for those working with the elderly in four areas of communication problems: aphasia, hearing impairment, parkinsonian, and loss of larynx. Emphasis will be on improving communication of/and with the elderly.
3. Hand outs will be distributed to reinforce info about communication problems of elderly and how best to meet the communication needs of their population.

Please give a brief description of material to be presented:

(description continued)

4. A question-answer period will be provided if time allows.

5. Speaker will participate with other faculty members in panel discussion at close of workshop.

SAMPLE VITA SHEET FOR INSTRUCTORS

NAME COURTIAL DONALD C.
(Last) (First) (Middle)

ADDRESS 8100 West "B" Street
(Number) (Street)

Belleville, IL 62223
(City) (State) (Zip)

EMPLOYER Physical Therapy Services - Memorial Hosp.

4501 North Park Drive
(Number) (Street)
Belleville, IL 62223
(City) (State) (Zip)

EDUCATIONAL DATA:	Institution	Major	Year
Basic Preparation	St. L. U.	Phy. Ther.	1960

Highest Degree Held B.S.

PREVIOUS EXPERIENCE, INTEREST OR EXPERTISE IN RELATION TO THIS EDUCATIONAL OFFERING:

20 years Physical Therapy, working toward MA in Holistic Health. Numerous courses in P.T., massage, acupuncture, yoga, meditation, health care, biofeedback, applied kinesiology, human potential, stress control - as participant and instructor.

Please give a brief description of material to be presented:

Mr. Courtial will use the holistic approach involving relaxation, biofeedback, acupuncture, touch for health, energy fields and applied kinesiology. The audience will be encouraged to participate in the demonstration of some of these methods. The theories involved in this relatively new method of treatment will be discussed. Nutritional aspects that can be used to prevent illness will also be discussed. The primary goal of this presentation is to increase the general knowledge of using the holistic approach to treat the elderly.

SAMPLE VITA SHEET FOR INSTRUCTORS

NAME WAYNE MARGARET A.
(Last) (First) (Middle)

ADDRESS 4119 Magnlia Avenue, #3
(Number) (Street)

St. Louis, MO 63110
(City) (State) (Zip)

EMPLOYER Memorial Hospital

4501 North Park Drive
(Number) (Street)

Belleville, IL 62223
(City) (State) (Zip)

EDUCATIONAL DATA: Institution Major Year

Basic Preparation Washington U. - Social Work - 1967

Highest Degree Held M.S.W.

PREVIOUS EXPERIENCE, INTEREST OR EXPERTISE IN RELATION TO THIS EDUCATIONAL OFFERING:

1967-1974 Social Worker
Department of Social Work
Department of Health & Hospitals
City of St. Louis (one responsibility
during this period was providing social
services to chronically ill elderly re-
ceiving home care services)

1977-1980 Faculty Member, School of Social Service
St. Louis U. (taught courses in health
care for social workers)

1980-Pres. Director of Social Service - Memorial Hosp.
Belleville, IL

Please give a brief description of material to be presented:

This presentation will concern itself with the social problems encountered with aging. It will focus in on the family problems encountered and ways in which the allied health professionals can assist in meeting the needs of both patients and family. Re-location trauma will be discussed along with the effect it has many times on our aged population. Information will be given on agencies available to assist the elderly in their home environment - hopefully preventing institutionalization. Alternatives to institutionalization will be discussed.

SAMPLE VITA SHEET FOR INSTRUCTORS

NAME GAIN, JR. OSCAR RAYMOND
(Last) (First) (Middle)

ADDRESS 1105 Forest Hills
(Number) (Street)

Belleville, IL 62221
(City) (State) (Zip)

EMPLOYER Memorial Hospital

4501 North Park Drive
(Number) (Street)

Belleville, IL 62223
(City) (State) (Zip)

EDUCATIONAL DATA:	Institution	Major	Year
Basic Preparation	St. Louis U.	B.S.	1974

Highest Degree Held B.S. - Physical Therapy

PREVIOUS EXPERIENCE, INTEREST OR EXPERTISE IN RELATION TO THIS EDUCATIONAL OFFERING:

I have been a Consulting Physical Therapist to four nursing homes since 1975. Presently the Assistant Director of Physical Therapy Services at a 425 bed hospital with approximately 40 employees in the department. Attended numerous seminars on aging including an International Conference on Aging.

Please give a brief description of material to be presented:

A physical therapist's approach in assessing and caring for the elderly institutionalized. I will give an example of an evaluation of a resident. A special acronym was developed to have an organized assessment of the geriatric patient. A list of basic equipment will be given and a list of optional equipment. There will be an outline for the lecture with blank lines so that the attendees will have an active role in the lecture. The evaluation form will not be too constricting, so that the attendees can modify it to their needs. Slides will be used in the lecture to ensure the audience is capable of following the lecture.

SAMPLE VITA SHEET FOR INSTRUCTORS

NAME BIEDENHARN (Last) PAUL (First) J. (Middle)

ADDRESS Medical Arts Building
(Number) (Street)

New Baden, IL 62265
(City) (State) (Zip)

EMPLOYER Geriatric Associates, LTD.

Medical Arts Building
(Number) (Street)

New Baden, IL 62265
(City) (State) (Zip)

EDUCATIONAL DATA:	Institution	Major	Year
Basic Preparation	Washington U.	A.B. Psychology	1959
Highest Degree Held	University of Ill.	Medicine - M.D.	1963

PREVIOUS EXPERIENCE, INTEREST OR EXPERTISE IN RELATION TO THIS EDUCATIONAL OFFERING:

15 years private practice - medicine last 10 years specializing in geriatrics.

Please give a brief description of material to be presented:

General discussion of M.D.'s role in health care to the elderly.

Dr. Biedenharn will again stress the importance of education for health care providers who work with the elderly. He will include knowledge in re: to dealing with institutionalized elderly and the importance of communication between the doctor and other professionals - stressing the need for better nursing assessments and diagnosis. In long term care, especially, the nurse must be the eyes, ears, and hands of the doctor. He will present examples as to how the nurse can improve her ability in relaying pertinent information to doctors.

A MULTIDISCIPLINARY APPROACH TO AGING

1. Intended Audience

This offering has been planned for professionals and allied health professionals in all disciplines who provide care to the geriatric population.

2. Evidence of Nursing Involvement

A Certified Gerontological Nurse and a Registered Physical Therapist planned this program. The nurse will present a forty-five minute lecture on "Nursing Assessment of the Elderly". Other speakers include a geriatrician, speech-language pathologist, social worker, and physical therapists.

3. Objectives

The objectives of this program are:

1. To increase general knowledge of the geriatric patient
2. To sensitize the allied health professional to the needs of the elderly
3. To stress the importance of team work
4. To improve knowledge and skill in assessing the health needs of the elderly
5. To improve care of the elderly now and in the future

4. Content

(See back of vita sheet)

A twenty minute film entitled "Aging" will be shown during the last twenty minutes of the lunch hour. It deals with some of the misconceptions associated with aging. It is hoped that it will reinforce some of the objectives of the program.

5. Instructors

   (See attached vita forms)

6. Evaluation Tool

   (See attached Sheet)

APPENDIX G

6 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60602 • (312) 236-9708

CONTINUING EDUCATION APPROVAL AND RECOGNITION PROGRAM
CRITERIA AND POLICIES

SINGLE OFFERINGS

GENERAL INFORMATION

The Illinois Nurses' Association defines continuing education as follows:

> Continuing Education in nursing consists of organized, systematic learning experiences designed to enlarge the professional knowledge and skills of nurses. Continuing professional education activities are applicable to the individual's current goals for the enrichment of competence, may be of short duration, and may be conducted in a variety of settings.

Continuing education is characterized by educational offerings designed to present newly emerging concepts of health care, principles, theories and research in health care and nursing which enhance the professional knowledge base and enable nurses to practice at increasingly higher levels of excellence.

The primary responsibility for continuing education rests with the professional nurse. Continuing education offerings may be obtained through a variety of ways from a diversity of sources such as: professional organizations, health related organizations, colleges, universities, etc. Fifty percent of the contact hours earned within a biennium may be obtained from continuing education programs sponsored by the employing agency, exclusive of orientation and on-the-job training. To protect individual licensure and avoid the threat of institutional licensure that might materialize if employing agencies provided all or most of continuing education for their professional employees, nurses are encouraged to seek continuing education outside of the employing agency whether school of nursing, hospital, industry, etc. The opportunity to enter into meaningful encounters with other professional practitioners may be found in various settings outside the immediate work situation and encourages the broad exchange of enriching ideas.

APPLICATION FORM — Application forms (7904) for INA-CEARP review are available upon request from INA headquarters.

FEES — The fee varies according to number of contact hours requested:

1-4 hour offering $15.00

5-12 hour offering $20.00

- over -

13-18 hour offering................................$25.00

19-hour and over offering.......................$35.00

Serial offerings.......................................$50.00

The fee for INA structural units and constituents (districts, divisions, commissions and councils) is 50% less than above.

Fee must be submitted with the application data.

WITHDRAWAL POLICY

Fees charged for the review process are not refundable.

SPONSORING AGENCIES

The INA Council on Continuing Education has identified the following as examples of appropriate sponsoring agencies:

A. the professional nursing organization
B. other nursing organizations (including nursing alumni associations, specialty organizations, etc.)
C. employing agencies (hospitals, health departments, visiting nurse associations, etc.)
D. health related organizations (cancer, heart, etc.)
E. colleges and universities
F. professional education groups (individuals or organizations, for-profit or not-for-profit, whose only activity is dissemination of professional education)

EDUCATIONAL OFFERINGS SUBMISSION DATE

Educational offerings submitted for INA-CEARP recognition must enter review prior to the first date of presentation. <u>No retroactive recognition will be granted</u>. In order to have full advantage of the review process, application data should be received at INA 30-[illegible] days in advance of presentation.

RECOGNITION PERIOD

Approval of single educational offerings is valid for two years from the date of approval.

PUBLICATION POLICY

A listing of up-coming INA approved continuing education offerings which are open to nurses outside the sponsoring agency will be published once, at the time of approval, in <u>Chart</u>. When an offering is repeated the information is not reprinted.

Sponsoring agencies that want recognized educational offerings included in the <u>Chart</u> listing are advised to submit application and fee at least 60 days in advance of presentation.

APPLICATION CRITERIA

TITLE

The title of the educational offering should be descriptive of the content to be presented. Example: Rather than "Cardiac Nursing" a course might be entitled "Nursing Implications in Caring for a Patient on Cardiac Monitor".

CONTACT HOURS

One contact hour (50 minutes) is the smallest acceptable unit for recognition under the INA-CEARP. A contact hour is defined as a unit of measurement to describe 50 minutes of an approved organized learning experience or 100 minutes of planned and supervised clinical practice which is designed to meet educational objectives. Fractions of an hour are not counted.

Allotment of contact hours shall be exclusive of time spent for lunch, breaks and membership activities.

The following data must accompany the application:

1. INTENDED AUDIENCE

Describes those persons for whom the educational offering (content and objectives) has been designed. If an offering has been planned for a specific group of nurses (critical care, general duty, clinical specialists, etc.) please indicate. This information helps the reviewers determine if the content is appropriate continuing education for that group.

2. EVIDENCE OF NURSING INVOLVEMENT

Evidence of nurse participation in planning and implementation of educational offerings seeking recognition under the Illinois Nurses' Association Continuing Education Approval and Recognition Program is required.

Examples of planning activities include:

A. identification of learning needs of participants
B. development of educational objectives
C. development of the program (securing the services of appropriate faculty and/or experts in the area of content, etc.)
D. evaluation of the effectiveness of the educational offering.

Examples of implementation activities include:

A. nurse presenter on the program and/or
B. nurse facilitator to elicit application and/or implications for nursing practice with nurse participants attending the educational offering.

3. OBJECTIVES

Objectives must be:

A. measurable
B. appropriate to the level of the learner
C. appropriate to the content presented
D. realistic and attainable for the time allotted

4. CONTENT

While it is recognized that some review of basic principles is sometimes helpful to introduce the newer concepts of care, the majority of time and content of a continuing education offering must primarily reflect knowledge which is current and evolving.

Content outline should include:

A. breakdown of content by hour
B. major ideas and salient points to be presented

- over -

C. instructor(s)
D. film(s) utilized in conjunction with content presentation, identified by title and duration (Audio-visual materials such as films and filmstrips are not acceptable as the sole means of providing content.)

Content must:

A. be relevant to the practice of nursing
B. be presented at an appropriate level for the professional nurse audience described
C. reflect the stated objectives
D. be reasonable for the time allotted.

Sufficient content must be submitted so the above may be evaluated by the reviewers.

If clinical practice and return demonstrations are utilized, they must be an integral part of the educational offering. Clinical portion must include:

A. objectives
B. activities
C. supervision
D. evaluation

5. INSTRUCTORS

Teachers shall be competent in the subject areas to be taught. This competence may arise from formal academic preparation and/or clinical expertise. A resume of information relevant to each instructor's expertise in the <u>area of content</u> to be presented must be submitted with the application. Job titles such as assistant professor, director of inservice, etc., are not sufficient.

A sample vita form is attached which contains essential data needed for review. This form may be duplicated for each presenter and submitted with your application.

6. EVALUATION TOOL

A copy of the tool to be used to obtain evaluation and constructive criticism from the participants must be submitted. The evaluation tool must include questions that provide an opportunity for the learner to evaluate:

A. the extent to which the content met the stated objectives. Objectives should be evaluated individually or a test/exam may be administered to cover the content presented.
B. each instructor
C. relevance of the content to the learner's work situation

REVIEW RESULTS

Sponsoring agencies are notified in writing of the action of the Review Committee immediately after each review. Letters of Approval indicate that all criteria have been met. Letters that indicate Deferral or Disapproval [illegible] the decision reached by the Review Committee. Deferred applications

REVIEW RESULTS continued — are re-reviewed at no additional fee, provided that additional information is received at INA in sufficient time to clear review before presentation.

APPEAL PROCESS — Sponsors of disapproved offerings may appeal the decision by requesting the Criteria Committee to review the offering as it was originally submitted. A letter requesting such an appeal must be sent to the Criteria Committee within 15 days of notification of disapproval. The fee for this appeal process is $5.00. 39.

If the decision of the Criteria Committee is to uphold the disapproval by the Review Committee, a final appeal may be made to the INA Commission on Continuing Education, and the coordinator will be invited to attend this review.

RESUBMISSION — Sponsors of disapproved offerings who do not choose the appeal process may submit additional information and use the recommendations of the Review Committee to strengthen their applications. Such offerings can then be resubmitted as <u>new</u> applications at the regular fee, taking into consideration that the original dates may have to be changed to allow the usual time (60 days) for the review process.

RESPONSIBILITIES OF SPONSORING AGENCIES

COORDINATOR — The coordinator is the person designated by the sponsoring agency to:

A. implement the educational offering
B. establish accurate and retrievable attendance records
C. record participant contact hours
D. prepare, validate and assure distribution of certificates of attendance
E. complete INA tally sheet indicating number of RNs in attendance
F. summarize evaluations

It is the coordinator's responsibility to determine the number of hours to be recognized for learners who attend only part of the program. The coordinator's judgement should be based on the offering's objectives and sound educational principles. If material is sequential and full attendance is required, learners should be so informed at the outset.

CERTIFICATES OF ATTENDANCE — The agency sponsoring an INA recognized offering must provide each participant with a recognition form which at least contains the following information:

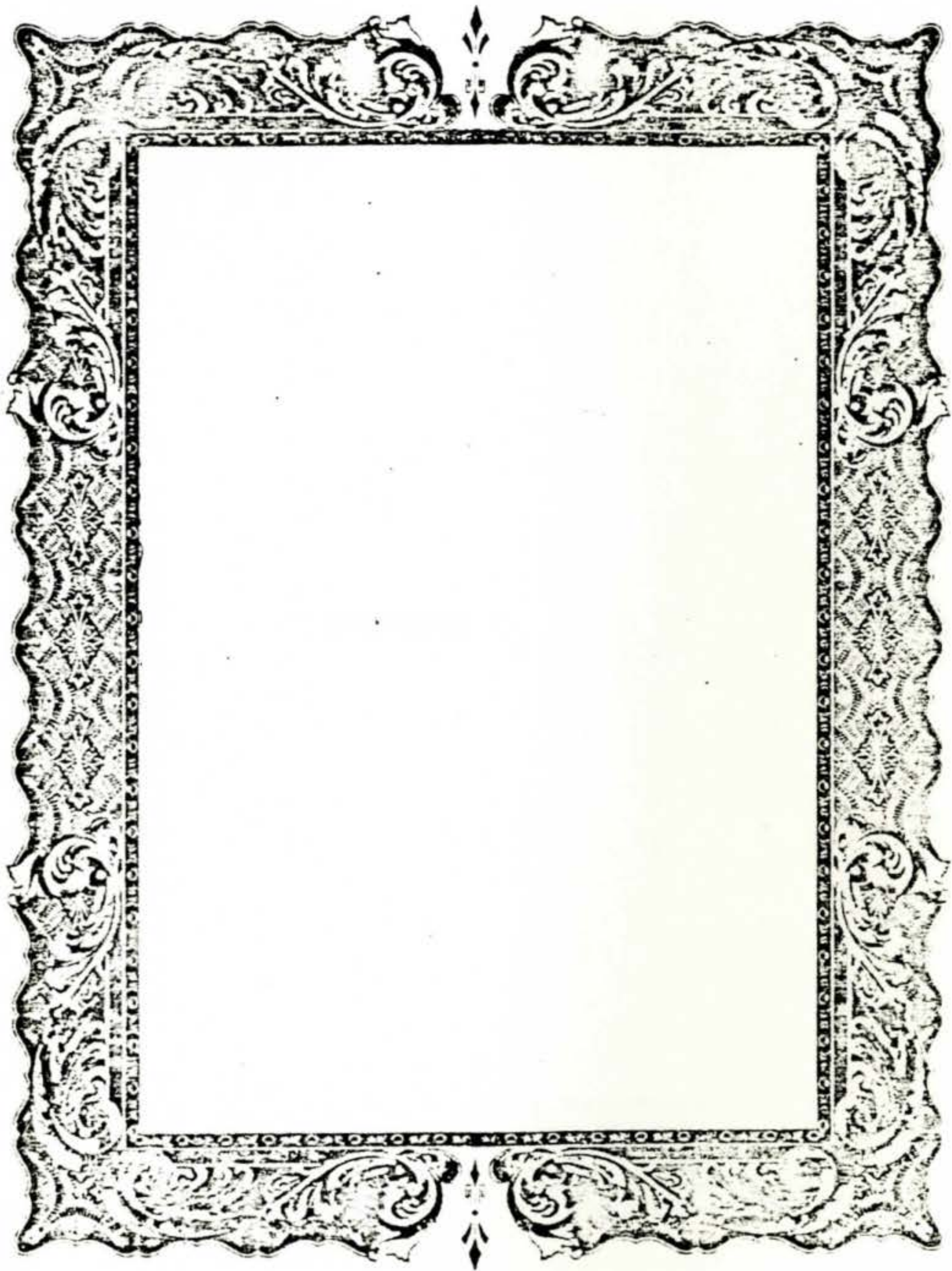
1. Name of sponsoring agency
2. Title of educational offering
3. Date of presentation
4. Name and signature of coordinator
5. Name of participant
6. Statement: "This offering (______________________) has
   biennial approval number
   been recognized by the Illinois Nurses' Association-Continuing Education Approval and Recognition Program for ________ contact hours, and endorsed by the American Nurses Association."

- over -

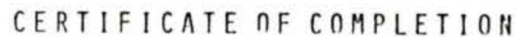
EVALUATION	The sponsoring agency must provide INA with a tally of those attending and a summary of evaluation results within a reasonable time after the completion of an approved offering.
CHANGES IN APPROVED OFFERINGS	If a change in objectives or content of an approved offering occurs during the two-year approval period, the offering must be re-submitted with fee as a new program. The application will be reviewed again and, if approved, a new INA-CEARP number will be issued. If the only change is in the coordinator and/or instructional staff, credentials of the new personnel must be submitted before presentation of the offering. No additional fee will be charged. Criteria for approved offerings repeated by a different sponsor are available from INA headquarters upon request.
MONITORING APPROVED OFFERINGS	From time to time, approved offerings will be selected for follow-up. Offering coordinators will be asked to furnish INA with a list of participants. INA will send an evaluative questionnaire to participants. The sponsoring agency will receive a summary of participant's responses. We anticipate that this cooperative effort will contribute to the maintenance of INA-CEARP's high standards.

11/75
MHG:ar
Revised 3/79

APPENDIX H



APPENDIX I



THIS IS TO CERTIFY THAT

____

HAS COMPLETED A COURSE ENTITLED

"A Multidisciplinary Approach to Aging"

"This offering (   ) has been recognized by the Illinois Nurses' Association - Continuing Education Approval and Recognition Program for (6) contact hours, and endorsed by the American Nurses Association."

SPONSORED BY

THE LINDENWOOD COLLEGES, ST. CHARLES, MISSOURI

August 28, 1981 ______________________________

____
COORDINATOR

APPENDIX J

I. INTRODUCTION

a) Objectives

1) Necessary equipment for a basic physical therapy department.

2) An easy assessment tool for assessing a new resident.

3) Future for physical therapy and extended care facilities.

II. BASIC EQUIPMENT

a) Parallel bars

b) Restorator/Bike

c) Pulleys

d) Free weights with velcro straps

e) Regular walker/Hemi-walker

f) Adjustable cane/Quad cane

III. OPTIONAL EQUIPMENT

a) Hydrocollator machine

1) Small verus large (depend on physical therapist's perference)

b) Col pac

c) Portable electrical muscle stimulator

d) Portable ultrasound

e) Diathermy

f) Small whirlpool

g) Trans-cutaneous nerve stimulator (TENS)

h) Exercise mat table

IV. ASSESSMENT TOOL FOR NEW RESIDENTS

Acronym: Many come close, very seldom can reach all proposed goals planned

APPENDIX K

EVALUATION FORM

"A Multidisciplinary Approach to Aging"

1. Do you feel that the Pre-test helped to increase your general knowledge of the elderly and alleviated some misconceptions?

   Yes________ No________

2. Did the seminar make you more aware of the needs of geriatric patients?

   Yes________ No________

3. Was the team approach stressed in the seminar?

   Yes ________ No ________

4. Will you be using any of the assessment tools presented at this seminar when you return to your place of employment?

   Yes ________ No ________

5. Do you feel that by attending this seminar, you will be able to improve the quality of care given to your patients?

   Yes________ No ________ In what ways will you be improving the care? ____

   ____

Evaluation of Speakers:	Outstanding	Satisfactory	Ineffective
Dr. Paul J. Biedenharn	________	________	________
Sandra K. Gain, R.N.C.	________	________	________
Oscar Gain, Jr., R.P.T.	________	________	________
Ann Carey, Ph. D.	________	________	________
Don Courtial, R.P.T.	________	________	________
Margaret Wayne, M.S.W.	________	________	________

6. Your job title or position ____________________________

APPENDIX L

Facts on Aging Quiz

T F 1. The majority of old people are senile (i.e. defective memory, disoriented, or demented).

T F 2. All five senses tend to decline in old age.

T F 3. Most old people have no interest in, or capacity for, sexual relations.

T F 4. Lung vital capacity tends to decline in old age.

T F 5. The majority of old people feel miserable most of the time.

T F 6. Physical strength tends to decline in old age.

T F 7. At least one-tenth of the aged are living in long-stay institutions (i.e. nursing homes, mental hospitals, homes for the aged, etc.).

T F 8. Aged drivers have fewer accidents per driver than drivers under age 65.

T F 9. Most older workers cannot work as effectively as younger workers.

T F 10. About 80% of the aged are healthy enough to carry out their normal activities.

T F 11. Most old people are set in their ways and unable to change.

T F 12. Old people usually take longer to learn something new.

T F 13. It is almost impossible for most old people to learn something new.

T F 14. The reaction time of most old people tends to be slower than reaction time of younger people.

T F 15. In general, most old people are pretty much alike.

T F 16. The majority of old people report that they are seldom bored.

T F 17. The majority of old people are socially isolated and lonely.

T F 18. Older workers have fewer accidents than younger workers.

T F 19. Over 15% of the U.S. population are now age 65 or over.

T F 20. Most medical practitioners tend to give low priority to the aged.

T F 21. The majority of older people have incomes below the poverty level (as defined by the Federal Government).

T F 22. The majority of old people are working or would like to have some kind of work to do (including housework and volunteer work).

T F 23. Older people tend to become more religious as they age.

T F 24. The majority of old people report that they are seldom irritated or angry.

T F 25. The health and socio-economic status of older people(compared to younger people) in the year 2000 will probably be worse or about the same as that of today's older people.

A short, factual, and documented quiz is developed and tested which covers the basic facts and frequent misconceptions about aging. Its uses include stimulating discussion, measuring levels of information and anti-aged bias, identifying the most frequent misconceptions, measuring the effects of courses, and measuring changes in public information or bias.

Facts on Aging
A Short Quiz[1]

Erdman Palmore, PhD[2]

Several tests or scales on aging have been developed and a few have been published (Golde & Kogan, 1959; Kogan, 1961; Tuckman & Lorge, 1952). However, these tests all share one or more of the following disadvantages:

(1) They tend to have 40 or 50 items and require several pages of print.

(2) They confuse factual statements (which may or may not be true) with attitudinal statements which are arbitrarily scored as being "favorable" or "unfavorable." For example, Kogan's statement "Most old people would prefer to continue working just as long as they can, rather than be dependent on anybody" is probably false, depending on what is meant by "most," "working," and "dependent." Yet, a "disagree" response is scored as showing an unfavorable attitude toward the aged. Unfortunately, some "negative stereotypes" about the aged are generally true and some of the "positive" statements are generally false.

(3) The factual statements are undocumented and we have nothing but the author's assertion that they are true or false.

The following quiz is designed to avoid these disadvantages. It is short (25 items requiring only one page and less than 5 minutes to complete) and confined to factual statements which can be documented by empirical research. It is designed to cover the basic physical, mental, and social facts and the most common misconceptions about aging. Before proceeding further, you are encouraged to try out the quiz to find out which facts you may be unaware of. Circle "T" for True, or "F" for False.

T F 1. The majority of old people (past age 65) are senile (i.e., defective memory, disoriented, or demented).

T F 2. All five senses tend to decline in old age.

T F 3. Most old people have no interest in, or capacity for, sexual relations.

T F 4. Lung capacity tends to decline in old age.

T F 5. The majority of old people feel miserable most of the time.

T F 6. Physical strength tends to decline in old age.

T F 7. At least one-tenth of the aged are living in long-stay institutions (i.e., nursing homes, mental hospitals, homes for the aged, etc.).

T F 8. Aged drivers have fewer accidents per person than drivers under age 65.

T F 9. Most older workers cannot work as effectively as younger workers.

T F 10. About 80% of the aged are healthy enough to carry out their normal activities.

T F 11. Most old people are set in their ways and unable to change.

T F 12. Old people usually take longer to learn something new.

T F 13. It is almost impossible for most old people to learn new things.

T F 14. The reaction time of most old people tends to be slower than reaction time of younger people.

T F 15. In general, most old people are pretty much alike.

T F 16. The majority of old people are seldom bored.

T F 17. The majority of old people are socially isolated and lonely.

T F 18. Older workers have fewer accidents than younger workers.

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T F 19 Over 15% of the U.S. population are now age 65 or over.

T F 20 Most medical practioners tend to give low priority to the aged.

T F 21 The majority of older people have incomes below the poverty level (as defined by the Federal Government).

T F 22 The majority of old people are working or would like to have some kind of work to do (including housework and volunteer work).

T F 23 Older people tend to become more religious as they age.

T F 24 The majority of old people are seldom irritated or angry.

T F 25 The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be about the same as now.

The key to the correct answer is simple: all the odd numbered items are false and all the even numbered are true. So far, no one taking the quiz has guessed this pattern of correct answers.

Documentation

(1) The majority of old people are not senile (i.e., defective memory, disoriented, or demented). Only about 2 or 3% of persons age 65 or over are institutionalized as a result of psychiatric illness (Busse & Pfeiffer, 1977). A series of eight community surveys found the prevalence of psychosis (of all types) to range from 4 to 8% (Riley & Foner, 1968). Thus, all the evidence indicates that there are less than 10% of the aged who are disoriented or demented. It is more difficult to get accurate estimates of the proportion with defective memories, partly because of the different types of memory defects and different methods of measuring it. However, most studies agree that there is little or no decline with age in short-term memory storage capacity (using the digit span test). Four studies did find large age differences in free recall of words, but two of them found no age differences in recognition of words in a list (Woodruff & Birren, 1975). As for long-term memory, various community surveys have found less than 20% of the aged who cannot remember such things as the past President of the United States, their correct age, birth date, telephone number, mother's maiden name, address, or the alphabet (Botwinick, 1976; Pfeiffer, 1975). Thus, it is clear that the majority of aged do not have such serious memory defects.

(2) All five senses do tend to decline in old age. Most studies agree that various aspects of vision, hearing, and touch tend to decline in old age. Some studies of taste and smell have not found a significant decline, but the best evidence indicates increases in taste and smell threshholds with age (Riley & Foner, 1968). Studies of structural atrophy in the tongue and nose with old age support the experimental evidence of decline in taste and smell (Birren, 1959).

(3) The majority of persons past age 65 continue to have both interest in, and capacity for, sexual relations. Masters and Johnson (1966) found that the capacity for satisfying sexual relations continues into the decades of the 70s and 80s for healthy couples. The Duke Longitudinal Studies found that sex continues to play an important role in the lives of most men and the majority of women through the seventh decade of life (Palmore, 1974).

(4) Lung capacity does tend to decline in old age. Both vital lung capacity (the volume of air that can be forcibly expelled in one breath) and maximum breathing capacity (the volume of air that can be moved in and out of the lungs in 15 seconds) declines on the average from age 30 onward (Shock, 1962).

(5) The majority of old people do not feel miserable most of the time. Studies of happiness, morale, and life satisfaction either find no significant difference by age groups or find about one-fifth to one-third of the aged score "low" on various happiness or morale scales (Riley & Foner, 1968). A recent national survey found that less than a fourth of persons 65 or over reported that "This is the dreariest time of my life"; while a majority said "I am just as happy as when I was younger" (Harris, 1975).

(6) Physical strength does tend to decline in old age. Studies of various kinds of muscular strength show declines in old age compared to young adulthood of 15 to 46% (Birren, 1959).

(7) Only 4.8% of persons 65 or over were residents of any long-stay institutions in 1970 (U.S. Census, 1970). Even among those age 75 or over only 9.2% were residents in institutions.

(8) Drivers over age 65 do have fewer accidents per person than drivers under age 65. Older drivers have about the same accident rate per person as middle-aged drivers, but a much lower rate than drivers under age 30

(National Safety Council, 1976) Older drivers tend to drive less miles per year and apparently tend to compensate for any declines in perception and reaction speed by driving more carefully.

(9) The majority of older workers can work as effectively as younger workers. Despite declines in perception and reaction speed under laboratory conditions among the general aged population, studies of older workers (the 12% who are able to continue employment) under actual working conditions generally show that they perform as well as young workers, if not better than younger workers, on most measures. When speed of reaction is important, older workers sometimes produce at lower rates, but they are at least as accurate and steady in their work as younger workers. Consistency of output tends to increase by age, as older workers perform at steadier rates from week to week than younger workers do. In addition, older workers have less job turnover, less accidents, and less absenteeism than younger workers (Riley & Foner, 1968).

(10) About 80% of the aged are healthy enough to engage in their normal activities. About 5% of those over age 65 are institutionalized and another 15% among the noninstitutionalized say they are unable to engage in their major activity (such as work or housework) because of chronic conditions. This leaves 80% who are able to engage in their major activity (National Center for Health Statistics, 1974).

(11) The majority of old people are not "set in their ways and unable to change." There is some evidence that older people tend to become more stable in their attitudes, but it is clear that most older people do change and adapt to the many major events that occur in old age such as retirement, children leaving home, widowhood, moving to new homes, and serious illness. Their political and social attitudes also tend to shift with those of the rest of society, although at a somewhat slower rate than for younger people (Cutler & Kaufman, 1975, Glenn & Hefner, 1972).

(12) Old people usually take longer to learn something new. Experiments have consistently shown that older people take longer than younger people to learn new material (Botwinick, 1967). Studies of on-the-job trainees also show that older workers tend to take somewhat longer to learn new jobs (Riley & Foner, 1968).

(13) But, it is not impossible for most old people to learn new things. The same studies (cited in #12) also show that most older persons can eventually learn new things about as well as younger persons, if given enough time and repetitions of the material to be learned.

(14) The reaction time of most old people tends to be slower than that of younger people. This is one of the best documented facts about the aged on record. It appears to be true regardless of the kind of reaction that is measured (Botwinick, 1967).

(15) Most old people are not pretty much alike. There appears to be at least as much difference between older people as there is at any age level; there are the rich and poor, happy and sad, healthy and sick, high and low intelligence, etc. In fact, some evidence indicates that as people age they tend to become less alike and more heterogeneous on many dimensions (Maddox & Douglas, 1974).

(16) The majority of old people are seldom bored. Only 17% of persons 65 or over say "not enough to do to keep busy" is a "somewhat serious" or "very serious" problem (Harris, 1975). Another survey found that two-thirds of the aged said they were never or hardly ever bored (Dean, 1962). The Duke Adaptation Study found that 87% of those 65 or over said they were never bored in the past week.

(17) The majority of old people are not socially isolated and lonely. About two-thirds of the aged say they are never or hardly ever lonely (Dean, 1962), or say that loneliness is not a serious problem (Harris, 1975). Most older persons have close relatives within easy visiting distance and contacts between them are relatively frequent (Binstock & Shanas, 1976). About half say they "spend a lot of time" socializing with friends (Harris, 1975). About three-fourths of the aged are members of a church or synagogue (Erskine, 1964), and about half attend services at least three times per month (Catholic Digest, 1966). Over half belong to other voluntary organizations (Hausknecht, 1962). Thus, between visits with relatives and friends and participation in church and other voluntary organizations, the majority of old people are far from socially isolated.

(18) Older workers have fewer accidents than younger workers. Most studies agree this is true. For example, a study of 18,000 workers in manufacturing plants found that workers beyond age 65 have about one-half

the rate of nondisabling injuries as those under 65, and older workers have substantially lower rates of disabling injuries (Kossoris, 1948).

(19) Only 10.3% of the population were age 65 or over in 1975 and this will probably not increase to more than 12% by the year 2000, even if completed fertility drops to zero population growth levels (Current Population Survey, 1975).

(20) Most medical practioners tend to give low priority to the aged. A series of 12 empirical studies all found that most medical students and doctors, nursing students and nurses, occupational therapy students, psychiatry clinic personnel, and social workers tend to believe the negative stereotypes about the aged and prefer to work with children or younger adults rather than with the aged. Few specialize, or are interested in specializing, in geriatrics (Brown, 1967; Campbell, 1971; Coe, 1967; Cyrus-Lutz & Gaitz, 1972; DeLora & Moses, 1969; Gale & Livesley, 1974; Garfinkel, 1975; Gunter, 1971; Miller, Lowenstein, & Winston, 1976; Mills, 1972; Spence & Feigenbaum, 1968).

(21) The majority of persons 65 or over have incomes well above the poverty level. In 1975 there were only 15.3% of the aged below the official poverty level (about $2,400 for an aged individual or $3,000 for an aged couple). Even if the "near poor" are included, the total in or near poverty is only 25.4% (Brotman, 1976).

(22) Over three-fourths of old people are working or would like to have some kind of work to do (including housework and volunteer work). There are about 12% of persons 65 or over who are employed, 21% who are retired but say they would like to be employed, 17% who work as housewives, 19% who are not employed but do volunteer work, and another 9% who are not employed and not doing volunteer work but would like to do volunteer work (Harris, 1975). These percentages total to 78%.

(23) Older people do not tend to become more religious as they age. While it is true that the present generation of older persons tend to be more religious than the younger generations, this appears to be a generational difference (rather than an aging effect) due to the older persons' more religious upbringing. In other words, the present older generation has been more religious all their lives rather than becoming more religious as they aged. Longitudinal studies have found no increase in the average religious interest, religious satisfaction, nor religious activities among older people as they age (Blazer & Palmore, 1976).

(24) The majority of old people are seldom irritated or angry. The Kansas City Study found that over one-half the aged said they are never or hardly ever irritated and this proportion increases to two-thirds at age 80 or over. About three-fourths said they are never or hardly ever angry (Dean, 1962). The Duke Adaptation Study found that 90% of persons over age 65 said they were never angry during the past week.

(25) The health and socioeconomic status of older people (compared to younger people) in the year 2000 will probably be much higher than now. Measures of health, income, occupation, and education among older people are all rising in comparison to those of younger people. By the year 2000, the gaps between older and younger persons in these dimensions will probably be substantially less (Palmore, 1976).

Uses

There are several possible uses for this quiz which we will discuss and illustrate. The simplest use is as a stimulus for group discussion and clarification of misconceptions. Whenever I have presented the quiz to a group, it always stimulates many questions and considerable discussion of the basis for these facts and of their implications.

Table 1. Facts on Aging Scores for Undergraduates, Graduates, and Faculty

Group	N	Mean % Right	Standard Deviation
Undergraduate students	87	65	11.2
Graduate students	44	80	7.5
Faculty	11	90	7.7

A second use is to measure and compare different groups' overall levels of information about aging. For example, Table 1 shows that a sample of Duke undergraduate students (in Introductory Sociology classes) got only two-thirds of the facts correct, compared to 80% correct among graduate students in human development (at Duke University and Pennsylvania State University), and 90% correct among faculty in human development (at Duke and Pennsylvania State). These differences also support the validity of the quiz. The only item on which more errors were

made by graduate students and faculty than by undergraduates is Item #22: "The majority of older people are working or would like to have some kind of work to do (including housework and volunteer work)." Apparently, most undergraduates believed correctly that the majority of aged do some kind of work or want to work, but there were 4 faculty and 5 graduate students who were unaware of how the various categories of working, housework, volunteer work, and wanting work or volunteer work, add up to well over half the elderly.

It would be interesting and useful to find out which age, sex, race, religious, regional, socioeconomic, and other groups have more or less correct information about aging.

A third use is to identify the most frequent misconceptions about aging. Table 2 shows that the most frequent misconceptions among the sampled undergraduates were that a large proportion of the aged are living in institutions (74% wrong); that a majority of the aged are frequently bored (74% wrong); that over 15% of the population are age 65 or over (86% wrong); and that a majority of older people have incomes below the poverty level (74% wrong). Almost half of even the faculty thought that a majority of the aged were in poverty. Notice that three of these frequent

Table 2 Percentage of Errors on Each Statement by Undergraduates, Graduates, and Faculty

	% Errors by		
Statement #	Undergraduates	Graduates	Faculty
1	7	0	0
2	40	14	27
3	16	2	0
4	21	16	9
5	12	0	0
6	2	7	0
7	74	27	0
8	40	27	18
9	37	2	0
10	9	0	0
11	47	9	0
12	47	30	9
13	5	0	0
14	7	7	0
15	9	2	0
16	74	73	55
17	42	16	0
18	42	18	0
19	86	55	36
20	56	9	9
21	74	50	45
22	2	11	36
23	63	44	18
24	58	73	0
25	21	18	18

misconceptions are negative stereotypes and that the other one exaggerates the problem of the aged by exaggerating the numbers of aged.

A fourth use is as an indirect measure of bias toward the aged. Errors on some of the items probably indicate a negative bias toward the aged: for example, if someone says it is true that a majority of old people are senile (#1), it probably indicates a negative image of the aged. On the other hand, errors on other items probably indicate a positive bias toward the aged: for example, if someone denies that the five senses tend to decline in old age (#2) it probably indicates an unrealistically favorable image of old age. We have classified sixteen items as indicating a negative bias if they are marked incorrectly: items numberd 1, 3, 5, 7, 8, 9, 10, 11, 13, 16, 17, 18, 21, 22, 24, and 25. On the other hand, we have classified five items as indicating a positive bias if they are marked incorrectly: items numbered 2, 4, 6, 12, and 14. Using these items, one can then compute a net anti-aged or pro-aged score by subtracting the percentage of errors on the negative bias items from the percentage of errors on the positive bias items. If the resulting score is negative, it indicates a net anti-aged bias; if it is positive, it indicates a net pro-aged bias. For example, 12 of the undergraduates had net anti-aged scores of 33 or more, and 5 had net pro-aged scores of 33 or more. Table 3 shows that the undergraduates and graduates tended to have more anti-aged errors than pro-aged errors, but that there was little difference in anti-aged and pro-aged errors among the faculty. About 2/3 of the undergraduates had net anti-aged bias. It would be useful to know which groups in the population tend to have high or low anti-aged bias.

Table 3 Pro- and Anti-Aged Errors for Undergraduates, Graduates, and Faculty

Group	N	Mean % Pro-Errors	Mean % Anti-Errors	% Pro minus % Anti
Undergraduate students	87	26	33	-7
Graduate students	44	15	20	-6
Faculty	11	9	11	-2

A final use of the quiz would be to measure the effects of lectures, courses, or other training experiences by comparing before and after scores, both total scores and the net anti-

aged scores. A longer test with multiple choice format might be a more sensitive measure, but this quiz has the advantage of requiring only a few minutes without taking much time away from the lecture or course itself. Similarly, periodic administrations of the quiz to representative samples of the public could be used to gauge changes in information levels and biases of the public as a whole.

Summary

Previous tests on aging tend to be long, undocumented, and confuse factual statements with attitudes. The present quiz is short (25 items on one page), documented, and consists of factual statements only. It is designed to cover the basic physical, mental, and social facts and the most frequent misconceptions about aging. It may be used to stimulate discussion; compare levels of information in different groups (undergraduates averaged 65% correct, graduates averaged 80%, and faculty averaged 90%); to identify frequent misconceptions; to measure anti-aged or pro-aged bias (there is usually more anti-aged than pro-aged bias), and to measure the effects of courses or training materials or to measure changes in information or biases over time.

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APPENDIX M

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APPENDIX N

THE FOLLOWING WRITING APPEARED IN PLAZA PULSE, MARCH 1976. NEVERTHELESS IT IS A TIMELY REMINDER FOR ALL OF US WHO WORK WITH AND CARE ABOUT THE ELDERLY.

NOTE: An old lady in a geriatric ward in Ireland died, apparently leaving nothing of value: then a nurse found this poem among her meager possessions.

"A Crabbit Old Woman Wrote This"
What do you see nurses, what do you see?
What are you thinking when you are looking at me...
A crabbit old woman, not very wise,
Uncertain of habit, with far away eyes.
Who dribbles her food and makes no reply
When you say in a loud voice...
"I do wish you'd try."
Who seems not to notice the things that you do,
And is forever losing a stocking or shoe.
Who unresisting or not, lets you do as you will,
With bathing, and feeding, the long day to fill.
Is that what you are thinking, is that what you see?
Then open your eyes, nurse, you're not looking at me.
I'll tell you who I am, as I sit here so still;
As I use at your bidding, as I eat at your will.
I am a small child of ten, with a father and mother,
Brothers and sisters, who love one another,
A young girl of sixteen with wings on her feet,
Dreaming that soon now a lover she'll meet.
A bridge soon at twenty...my heart gives a leap,
Remembering the vows that I promisec to keep.
At twenty-five, now I have young of my own,
Who need me to build a secure, happy home.
A woman of thirty, my young now grow fast,
Bound to each other with ties that should last.
At forty, my young sons have grown and are gone,
But my man's beside me to see I don't mourn.
At fifty once more babies play 'round my knee.
Again, we know children, my loved one and me.
Dark days are upon me, my husband is dead,
I look at the future, I shudder with dread,
For my young are all rearing young of their own,
And I think of the years and the love that I've known.
I'm an old woman now and nature is cruel...
"Tis her jest to make old age look like a fool.
The body, it crumbles, grace and vigor depart.
There is now a stone where I once had a heart.
But inside this old carcass, a young girl still dwells,
And now and again, my battered heart swells.
I remember the joys, I remember the pain,
And I'm loving and living life all over again.
I think of the years all too few...gone too fast,
And accept the stark fact that nothing can last.
So, open your eyes, nurses, open and see
Not a crabbit old woman, look closer...
see "ME"!

NURSING ASSESSMENT FORM

History of Present Illness: ____________________

____

____

____

Source: ____________________

Past History:

Medical____________________

____

____

Surgical ____________________

____

____

Misc. (include medications taken at home, eating problems, bowel habits, and sleeping pattern) ____________________

____

____

Allergies ____________________

Review of Systems:

HEENT____________________

____

____

Cardio-respiratory ____________________

____

G.I. ____________________

____

G.U. ____________________

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Musculoskeletal ______________________________

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Neuropsychiatric ______________________________

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Integumentary ______________________________

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____

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Evaluating Nurse

APPENDIX O

PHYSICAL THERAPY

I. INTRODUCTION

II. BASIC EQUIPMENT

III. OPTIONAL EQUIPMENT

IV. ASSESSMENT OF A GERIATRIC PATIENT USING THE ACRONYM

M__________ R__________

C__________ A__________

C__________ P__________

V__________ G__________

S__________ P__________

C__________

MENTAL
(Brown)
COMMUNICATION
(Chushid)
CRANIAL NERVES
(Steegmann)
VOLUNTARY MUSCLE MOVEMENTS
(Chushid)
SENSORY
(Chushid)
CO-ORDINATION
(Allen)
REFLEXES
(Allen)
ADL
(Rusk)
POSTURE
(Steegmann)
GAIT
(Patten)
PROGNOSIS

a) Mental

1) Time, place, person

b) Communication

1) Aphasia

a. receptive
b. expressive

c) Cranial Nerves (Optional)

Acronym: On Old Olympus Towering Top, A Fin And German Viewed Some Hops

1. Optic
2. Olfactory
3. Oculomotor
4. Trochlear
5. Trigeminal
6. Abducens
7. Facial
8. Auditory
9. Glossopharyngeal
10. Vagus
11. Accessory
12. Hypoglossal

d) Voluntary Muscle Movements

1) Active

a. Grade of strength

1. trace
2. poor
3. fair
4. good
5. normal "+" or "-"

2) Compare right and left side

3) Range of motion (generally decreased in shoulders, hips and knees)

e) Sensory

1) Light touch
2) Pin prick
3) Hot/Cold
4) Proprioception
5) Hearing
6) Seeing

f) Co-ordination

1) Alternating hads on lap
2) Ankle to knee
3) Hand to shoulder, elbow, wrist
4) Finger to nose

g) Reflexes

1) Babinski
2) Biceps, triceps, brachial-radialis, quadriceps and gastrocnemius jerks
3) Clonus

h) Activities of Daily Living

1) Turning in bed
2) Transfering
3) Feeding
4) Dressing

I) Posture

1) List to one side
2) Poor sitting balance
3) Kyphosis/Scoliosis

j) Gait

1) Parallel bars, walker, cane, crutches
2) Amount of assist, one, two or more
3) Standby, minimal, moderate, maximum
4) Transfer only, 4, 10, 20, greater then 50 feet

k) Prognosis

1) Guarded, poor, fair, good, excellent

APPENDIX P

PRE-REGISTERED	28	
PHONE-IN REGISTRATIONS	4	
ON-SITE REGISTRATIONS	2	
TOTAL:	34	
DISCIPLINES		
REGISTERED NURSES	19	56%
LICENSED PRACTICAL NURSES	6	18%
NURSE AIDES	1	3%
ADMINISTRATORS	1	3%
PHYSICAL THERAPIST ASSISTANTS	3	8%
PHYSICAL THERAPIST AIDES	2	6%
ACTIVITY DIRECTORS	1	3%
SOCIAL WORKERS	1	3%
TOTAL:	34	100%
LONG TERM CARE FACILITIES	14	
HOSPITALS	.1	
TOTAL:	15	
NUMBER OF REGISTRANTS PER FACILITY	2.2	
NUMBER OF REGISTRANTS FOR C.E.U. FROM I.N.A.	33	
NUMBER OF REGISTRANTS FOR C.E.U. FROM LINDENWOOD	1	
PRIVATE PAID REGISTRANTS	8	24%
FACILITY PAID REGISTRANTS	26	76%
TOTAL:	34	100%

APPENDIX Q

EVALUATION FORMS RETURNED	30		88%
	OUTSTANDING	SATISFACTORY	INEFFECTIVE
DR. PAUL BIEDENHARN	26	4	0
SANDRA K. GAIN, R.N.C.	22	8	0
OSCAR R. GAIN, JR., R.P.T.	16	14	0
DR. ANN CAREY	20	10	0
DONALD COURTIAL, R.P.T.	23	6	1
MARGARET WAYNE, M.S.W.	7	20	3

RESPONSES TO QUESTIONS ON EVALUATION FORMS

	YES	NO
QUESTION 1	27	3
QUESTION 2	30	0
QUESTION 3	30	0
QUESTION 4	29	1
QUESTION 5	28	2

APPENDIX R

Multidisciplinary Approach To Aging - BUDGET

Date	Item	EXPENSE	INCOME
8-01-81	Advanced $50.00 to open checking account	$	$50.00
8-04-81	I.N.A.	25.00	
8-07-81	Cash (Stamps - Labels)	20.00	
8-09-81	Name tags - S.G. Adams	4.84	
	Folders (100) - Target	12.63	
	Paper clips - 200	.43	
	Yellow zerox paper (200)	2.00	
	Carlyle Healthcare Center, Inc. (3)		60.00
8-11-81	Mary Ellen Wang		20.00
	Ann McEvilly		20.00
	Rosann Harris		20.00
	S.G. Adams - paper tablets	7.90	
	Target - film and folders	13.42	
8-12-81	K-Mart - film	4.60	
	Monroe County Nursing Home (2)		40.00
	Dolgins - film x2	11.75	
8-14-81	Film developed - Dicor	5.37	
8-17-81	Weir Nursing Home (3)		60.00
	Pleasant Rest Home (3)		60.00
	Lady of Snow (1)		20.00
	Almeda Kroupa		20.00
8-19-81	Film developed - Dicor	8.74	
	Slides made (3) Belle-Flair	18.00	
	Harlean Recklein		20.00
	Sr. Ambrosia Waller		20.00
8-20-81	Eunice Smith Nursing Home (2)		40.00
8-22-81	Canterbury Manor Nursing Home (2)		40.00
	Lindenwood - Registration	25.00	
8-26-81	Castle Haven Nursing Home (2)		40.00
	Briarcliff Nursing Home (2)		40.00
8-27-81	Gloria Heger - Four Fountain		20.00
	Film - Wall Mart	2.81	
8-28-81	Robin Silencik - Edencare		20.00

		EXPENSE	INCOME
8-28-81	Freeburg Care Center (3)	$	$60.00
	Diana Martinez		25.00
	Sister Michael Ryan		25.00
	Food, coffee, tax, tip	362.70	
	Honorariums: Dr. Biedenharn	50.00	
	Dr. Carey	50.00	
	Donald Courtial	25.00	
	Margaret Wayne	25.00	
	Lindenwood - 1 C.E.U.	5.00	
	Dr. Biedenharn returned honorarium		50.00
8-29-81	Return of advancement to open checking account	50.00	
TOTALS:		$730.19	$770.00
CREDIT:			$39.81

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