The Family Respite Center: Day Care for the Demented

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LOOSING A MILLION MINDS:  
CONFRONTING THE TRAGEDY OF ALZHEIMER'S DISEASE AND OTHER DEMENTIAS

Contractor Documents

Part 3:  
Special Care Programs and Facilities

March 1987

THE OTHER TITLES APPEAR ON THEIR OWN INDIVIDUAL MICROFICHE UNDER THE APPROPRIATE CLASS NUMBERS.

Designing a Residential Care Unit for Persons with Dementia, Dorothy H. Coons, Institute of Gerontology, University of Michigan, Ann Arbor, Michigan 48109

Experiences of the Atlanta Area ADRDA in the Development and Management of the Community Services Program, Carolyn J. French, Atlanta Area Chapter, Alzheimer's Disease and Related Disorders Association, Atlanta, Georgia 30340

The Family Respite Center: Day Care for the Demented, by E. Noyes and Richard Wittenborn, Family Respite Center, Inc., Falls Church, Virginia 22043

The Family Survival Project, Diana M. Petty, Family Survival Project, San Francisco, California 94115

Evaluation of a 24-hour Care System for Persons with Alzheimer's and Related Disorders, J. Daniel Sands and Judy Belman, Harbor Area Adult Day Care Center, Costa Mesa, California 92627

Institutional Approaches to the care of Individuals with Dementia, Audrey S. Weiner, The Hebrew Home for the Aged at Riverdale, Riverdale, New York 10471

Urinary Incontinence in Alzheimer's Disease, Thelma J. Wells, School of Nursing, University of Michigan, Ann Arbor, Michigan 48109

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PLANNING

The Alzheimer's Disease and Related Disorders Association, Northern Virginia Chapter (ADRDA-NOVA) is a local chapter of a national organization which was founded less than five years ago. The organizations' primary charge is to provide family support, community education and research assistance regarding conditions which result in dementia. Individual chapters also have the responsibility for aiding afflicted individuals and their families in their search for support services. ADRDA-NOVA has been in the forefront in identifying community needs and helping families take advantage of existing services. As gaps in services are identified, the chapter has been instrumental in creating solutions to these problems. In 1983 the chapter worked with a local hospital to establish the Dementia Resource Center, a multifaceted health center for the demented. This provided a community focus for dementia, a diagnostic clinic and management; counseling and educational services for family members; and a speakers bureau for community education. Shortly after the development of the DRC another gap in community services was recognized; there was no adult day care for the severely impaired patient with dementia.

This paper will describe how a new service evolved from a good idea into a five day a week operation. This center, the Family Respite Center (FRC) is unique in Northern Virginia because its' client population is all are demented and because it maintains a role as a sister organization of ADRDA-NOVA.
A Chronological Review

The origin of the Family Respite Center can be traced back to a meeting of an ADRDA-NOVA support group in 1982 wherein family members expressed their need for help in caring for affected relatives late in the stages of their disease. As these patient's diseases progressed and they became more demented, many were turned away from daycare centers that they had been attending or were refused admission to centers as new participants.

Although it took an enormous personal commitment, family caregivers wanted to maintain their relatives at home, in their own community. For the majority, there was a positive desire to maintain the patient in a noninstitutionalized home-like environment for as long as possible. In addition, a significant number of families could not afford the twenty thousand dollars a year or more required for a nursing home. So at a time when the burden of care was increasing, help available in the community was decreasing. Family members would resist the recommendation of nursing home placement, but often had nowhere else to turn. Typically, the only alternative was to hire professional caregivers or sitters for the time when a family member was not available. The cost of this was significant and often these individuals were not available or were not available in a reliable fashion. They were untrained in care of the demented and frequently would not return after one or two visits.

The members of the ADRDA NOVA Chapter brought this dilemma to the attention to the general membership and to the Board of Directors of the chapter. A variety of formal and informal
discussions ensued. Families wanted a place that would give them a break from the relentless demands of caregiving particularly during the later more difficult stages of the disease. It was clear that there was a gap between the perceived needs of the family members and the existing care facilities in the community. In particular troublesome behaviors for daycare centers would include problems with incontinence, wandering or other behavioral problems. These "other" problems mentioned by family members included aggression directed towards staff or other participants in the center or interfering with the staff or other participants as well. Many Alzheimer's patients go through a period of increased motor activity which can be disruptive without actually interfering with other individuals activities. A number of patients simply did not participate in the activities of the Center and often the staff was frustrated by this and did not feel they were providing a useful service to these individuals.

The Chapter responded by forming a planning committee which addressed three initial considerations. First was to ascertain the resources currently available in the community. Second was to document a reasonably broad base of support for and anticipated participation in the center. Third was to identify a program of care which would remedy the difficulties experienced by the ARDA NOVA families. The Chapter was fortunate in receiving an initial promise of financial support from the Knights of Columbus, Mount Vernon Council. This support allowed the ADRDA-NOVA Chapter to investigate the situation and resulted in
planning for an independent alternative daycare center.

During the summer of 1983 members of the ADRDA NOVA planning committee made site visits to a number of adult daycare centers and contacted others by phone. No existing adult daycare center in the geographic area met the requirements of the ARDA-NOVA community. However, two centers were identified which catered specifically to victims of Alzheimer's type illness. These programs were The Harbor Area Adult Daycare Center in Costa Mesa, California and the Burke Rehabilitation Center in White Plains, New York. Both of these centers had effectively addressed many of our issues. Mrs. Lin Noyes was able to make site visits which provided a concrete example that a number of ADRDA goals could be met in a reasonable fashion. The Harbor Area Adult Daycare Center visit had a significant impact on planning. (Sands, 1983) In addition to giving families respite it was clear that many of their clients responded to the program by improved performance, increased life satisfaction and a slowing of their functional decline. As a result of these site visits the goals of the proposed center were redefined to include a therapeutic effect on the participants in addition to relieving the burden of the family.

With all of this information in hand ARDA-NOVA hired a healthcare consultant to put together a proposal for what was to become the Family Respite Center. The planning committee felt that actually writing a formal plan for a venture such as this was beyond the scope of a volunteer group. The issues here were time, expertise, and experience; particularly if the project were to be done in a timely fashion. The consultant, relying heavily
on the experiences at Harbour Area and Burke Rehabilitation Centers put together a practical plan on how to open and run the daycare center. This took six weeks. In November of 1983 the proposal was accepted by the ADRDA Board. The plan accompanies this report (Appendix A).

Finding space took six months. In June, 1984 the Archdiocese of Arlington made available an unused portion of a parochial high school for one year only. The disadvantages of having to move were weighed against the advantages of no rent and the space's immediate availability. It was decided to accept the Bishop's offer thinking it was better to "sell" a viable program rather than an idea. During the summer cleaning and renovation was performed with considerable help from community volunteers. In July, 1984 the Family Respite Center became a non-profit corporation and in September the doors were opened on a part-time basis (three days a week). Full-time functioning was reached in April 1985.

Once the initial operation had begun the issue of a permanent home had to be addressed. In January of 1985 the search for space began again. This resulted in an ongoing re-evaluation of potential need, possible locations, projections of expenses and revenues all of which had to be considered in the context of each possible site. Finally the Chesterbrook Presbyterian Church in Falls Church, Virginia was selected. This was close enough to the original location to honor the commitment to the original clients and it was also closer to areas with large populations of elderly individuals. Rent at this site was low since the
church is also non-profit, and this kept costs low as well. In June of 1985 the Center moved to its present quarters.

In summary the key elements for the successful planning of this Center were a clearly defined need; a committed parent organization; and a specific goal. Of particular importance in turning concern or interest into a concrete plan was the initial donation of $11,000 from the Knights of Columbus.

Funding

The gift from the Knights of Columbus was the initial source of money for the FRC. In the beginning the only other source was individual donations to ARDA-NOVA ear-marked for the center. In July 1984 the Knights of Columbus gave another $5000 for a total of $16000. This was the funding for the costs of planning the center and the initial start-up. The Clark Charitable Trust made a large donation of $50000 in December, 1984. This with a smaller grant from the Northern Virginia business community guaranteed the centers solvency for a year of operation. This allowed the director and the Board of Directors to concentrate on issues of quality of care and evolving the program rather than searching for funds to keep the doors open. In addition the local business donations gave the center credibility and heightened local awareness of the Center's activities.

Administration & Operation :

1. Organizational Structure

The Family Respite Center is a not-for-profit 501(C)(3) corporation registered in the Commonwealth of Virginia. During the initial discussions a variety of structures were considered. A co-operative was an initial choice, but Virginia does not
allow them to have tax exempt status. This was a great economic barrier. The lack of a professional staff was felt to be a significant liability both in terms of reliability and marketing. The time commitment of working caregivers would also preclude their participating in such a structure. For these reasons, the Coop idea was abandoned. A for profit adult daycare center was felt to be inconsistent with the goals of the parent organization. It would have required significantly more capital to get started and there would not have been the cooperation of the other charitable institutions which have facilitated the Center. There was also the potential that the need to make money would compromise the commitment to expand and innovate in the area of dementia daycare. The possibility of having the Center as a subsidiary of the ARDA NOVA Chapter was considered. This was rejected for a variety of reasons. Most concrete was the legal liability that ARDA would have to assume. ARDA-NOVA is a volunteer organization with a variety of obligations. Running a daycare center would have stretched its' resources and would clearly be outside normal chapter duties and there was the potential conflict of interest for ARDA when it had to deal with other suppliers of adult daycare in the community. It would also divert many of the resources available to the ARDA Chapter from its role in the community to serving the relatively narrow focus of the Family Respite Center. Eventually an independent corporate structure for the FRC, was selected with its own Board of Directors. There are overlaps with the ADRDA-NOVA Board of Directors, but the relationship between the two organizations is
cooperative but distinct. This relationship of the Family Respite Center, ADRDA-NOVA and the DRC are shown in Figure 1.

As with any formal corporate structure there is a Board of Directors which oversees the corporation and a set of bylaws by which the corporation is run. The corporation must pay $25.00 annual fee to the state and report major changes in organization in a timely fashion.

The initial 501(C)3 status was granted provisionally after an initial evaluation and in 1989, the fiscal records of the corporation will be submitted to the IRS and reviewed. At that time a final determination will be made. This tax-exempt, non-profit status is very important in pursuing donations. It also generates a certain altruistic credibility about the center in the community. A lawyer was engaged to obtain the status and an outside accounting firm is employed to make sure financial records are in order.

Licensure

The Family Respite Center is licensed by the Dept. of Social Welfare of the Commonwealth of Virginia. This requires a zoning permit, a building inspection, a Health Department inspection and a fire inspection. It encompasses a global review of the Center's facilities and activities. There are strict requirements with respect to the number of clients and the amount of space and facilities that have to be provided. This resulted in only minor changes in our physical plan. The licensing of non-profit daycare centers in Virginia is not mandatory. The Board felt that obtaining licensure was a way of contributing to the establishment a community standard for adult daycare for the
Figure 1. Relationship of ADKDA-NOVA, FRC to DRC
elderly. It also reinforced the idea that adult daycare centers should be monitored in order to maintain adequate standards of care for the participants.

**Board Of Directors**

The initial Board of Directors for the FRC were members of the ARDA-NOVA Planning Committee. The bylaws stipulate that three of the FRC Board members will always be members of the ADRDA-NOVA Board of Directors. This was done to preserve the original character of the organization. The interlocking directorate facilitates the innovative and exploratory aspects of the ARDA-NOVA Chapter as it was reflected in the evolving concept of dementia specific adult daycare in this community. It assures that the people in the community would have access to the FRC at all levels including the decision making and planning level. It also guaranteed a number of members of the board who had a personal and individual commitment to patients with Alzheimer's Disease. A selection of Board members were taken from outside the ARDA Chapter in order to maintain the independence of the two organizations and preserve their somewhat divergent purposes. Board members were recruited on an individual basis by personal contact. Much of this was done to facilitate a specific purpose such as financial planning, fund raising, or marketing. The Board was specifically designed to be a working Board. A provision was made for a second honorary Board which would include individuals who had an interest in the Center and were willing to support it but could not make the significant time commitment of the full Board members.
Board meetings are required quarterly, however, extraordinary meetings have occurred on a monthly basis to meet the needs of the rapid evolution of the Center. There is provision in the by-laws for telephone polling of the Board which ensures an active involvement in major decisions. The Board of Directors sets policy for the Center's operation, approves a yearly budget and acts on applications for scholarship funds for individuals. The Board takes an active role in raising money for the Center in general and scholarships in particular. The Director of the Center is an ex-officio member of the Board and does much of the specific work on planning expenses. The Board has divided itself into smaller subcommittees to address specific tasks such as fund raising campaigns, planning renovations of the Center etc. These are generated and dissolved in an ad hoc fashion. All directors are volunteers. Expenses are reimbursed, but no compensation is given.

**Staff Of The Center**

The center has a paid staff consisting of a director, assistant director, activity director, program assistants, and a general assistant.

**Staffing.**

The ratio of staff to clients is one to five and the ratio is never decreased. Volunteers augment the staff's efforts. The involvement of volunteers is desirable because it increases the personal attention for each client and it brings a continuing fresh perspective to the center.

**The Director Of The Center.**
The initial responsibilities of the Director of the Center were two fold. First was the setting of a day to day policy and procedure for the initial start up period of the center. This was accompanied by a need to intergrate the Center with other services in the community including home health agencies and other short term respite resources. The Director has responsibility for an outreach program generating talks within the community. These talks raise the level of community interest in and understanding of Alzheimer's Disease. They also facilitate the community's appreciation for the role of dementia specific daycare in the clinical course of the Alzheimer's patient. The Director of the Center is responsible for the staffing of the Center, reviewing participant admissions and discharges, overseeing the functioning of the Center and acting as advocate during Board meetings.

**Assistant Director.** This individual is responsible for the day to day operation of the Center, orientation of staff, scheduling, and oversight of the volunteers program.

**Activity Director And Program Assistants.** The Activity Director is responsible for the activities of the clients on a by hour basis, helps plan activities for clients to create a balance of activity and rest. Two Program Assistants help the participants with their activities and personal care. Although these three have client contact as their principal responsibility, all staff members work with clients on a day to day basis. The Activity Director must have a degree, be able to lead groups and supervise the activities of the program assistants. There is a part-time General Assistant who functions
as a "person Friday", helping with participants, Center operations or typing and office work. Specific job descriptions are shown in the Plan (Appendix A).

**Staff Recruitment.**

The position of Director of the Center was advertised widely in nursing and geriatric publications. The requirements were for an advanced gerontological degree, experience with demented patients and administrative skills. Once the Director had been selected that individual hired the staff. The rest of the staff was recruited locally through advertising in newspapers, bulletin board announcements and training sites. Several employees began as volunteers at the Center and subsequently decided to commit themselves to a fulltime working status. This required a provision for considerable on the job training.

The significant threat of continuity within the staff is their ability to manifest their general concern for the participants in the context of their dementing processes. They are able to perceive the participants as parts of a larger family and community structure who are helped by the FRC rather than as individual isolated clients who need custodial care. Certainly there is a considerable dedication and self sacrifice in these individuals. In addition to this strength of character there is a willingness to learn and adapt that is extraordinarily important. In part this is because the concept of dementia specific daycare is relatively new and still evolving. There is also such a diverse range of behavior that any individual client can manifest that the workers must be able to learn and respond
to this variability.

**ORIENTATION**

The new staff is formally oriented by the Director and Assistant Director. This introduces them to the Center's policies, philosophies, activities and programs. There is in depth instruction in the nature of Alzheimer's Disease and other dementing conditions. Millieu therapy is explained and the employees' role in the participants' environment is emphasized. There are specific instructions in individual caregiving techniques. In such a small operation informal orientation is as important as formal orientation. This is accomplished through a cooperative group effort. Senior staff is expected to orient new staff by providing a role model as well as instruction. When group weaknesses are identified staff meetings are used as an educational forum. Continuing education programs are held regularly to update the staff on advances in the field. New staff and volunteers are encouraged to attend programs sponsored by the FRC or ARDA-NOVA to increase their knowledge and skills. A small amount of money is set aside by the Board of Directors for continuing education.

On the job training is extensive and new staff members are not left alone with the participants until the whole staff is comfortable with the situation. It is also important that the clients are also comfortable with the new staff and this is also taken into account.

**Day to Day Operation**

The Center is open five days a week Monday through Friday from 7:30 am to 5:30 p.m. The hours were chosen to accommodate
the caregiver who commutes to work and staff hours are staggered to accommodate a 10 hour day. The Center has a schedule of planned activities for each day which are chosen to meet the clients needs for physical exercise, entertainment and facilitation of communication skills. The staff is expected to balance the need for structure during the day with the variable needs of the group on any individual day. Staff members are expected to be aware of the individual client's mood and day to day changes in lucidity. This is done to tailor activities to meet individual needs. Participants are never forced to join in activities. Every client is reinforced for their participation in an activity no matter how tangential that participation may be. Even individuals who choose not to join in an activity are asked how they perceive or feel about the activity. In this context improving the client's self image concomitantly improves their community living skills. As they are integrated into a group and function within it, their physical and social adjustment improves. In many cases their personality returns toward their premorbid state.

**Budgeting And Revenues**

The FRC has a maximum capacity of twenty patients per day. The daily fee of $22.80 was calculated to allow the center to roughly break even at capacity. We were aware of the number of indigent elderly. No patient has been turned away from the center for lack of funds. The center does not anticipate covering expenses from client fees as we have an active scholarship program. Scholarships are partial or complete. Because of this program we
will need continuing community support. The greatest source of revenue has been donations. Client fees have become increasingly important as the patient population has increased.

Most of the expenditures were directly related to program services. Salaries were the largest expense. During the first year a number of non-recurring expenses such as consulting fees, moving expenses and legal fees were incurred. Rent, food, insurance, and consumables were the primary expenses. A copy of the first annual report accompanies this paper and details the centers financial picture. (Appendix B)

PROGRAMMING

The original therapeutic goals for those who suffer with Alzheimer's Disease were very limited. In general they were vague, symptomatic and not found to be particularly helpful by families and professionals given the task of the day to day care for demented individuals. The knowledge that the disease itself is inherently progressive tempered much of the health care community's enthusiasm for working with these individuals. Practical plans for implementing the circumscribed goals which existed were virtually nonexistent.

Milieu Therapy

During the 1960's the Institute of Gerontology at the University of Michigan applied the theory of therapeutic milieu with a group of older adults, many of whom were suffering significant cognitive decline. (Boudreault, M.F., 1975) In a descriptive study they were able to identify certain elements in the environment of older, confused people which enhanced their
ability to regain or maintain levels of function. They also were able to document an increase in participants' satisfaction with their lives.

The planners of the FRC were first introduced to the concept of therapeutic milieu for Alzheimer's patients at the Harbor Area Adult Day Care Center in Costa Mesa, California during an on-site visit before the FRC opened. This visit had a significant impact on our plans for the Respite Center. The original plans were somewhat limited; providing supervision for individuals that no one else would take in was the primary goal. The planning committee had decided to provide whatever services were necessary to give the families of the participant some respite during the work day. The emphasis was on the family and their needs, not on helping the individual participants or designing a program with therapeutic potential. In discussing the effectiveness of the day care center at Costa Mesa with their participants, families and staff, it became clear that there is a global improvement in the level of functioning of the clients and their families with the institution of milieu therapy.

The Michigan group had been able to document that a carefully constructed environment could produce significant improvement in the performance of patients with dementia. The Harbor Area Adult Daycare Center was a demonstration that this experiment could be translated into working model. In essence a structured, sheltered, supportive environment is created. The patient becomes comfortable in an environment they are familiar with. This includes the staff of the Center, the physical plant and the other participants. The individual is encouraged to work in a
cooperative fashion with the staff and other participants. The tasks which are generated are in some sense functional and parallel the patterns of their prior life. The participant receives an appropriate amount of cheerful support and appreciation for their activities within the context of this environment. This produces a significant increase in life satisfaction which may not be remembered as a specific cognitive event but which seems to improve the overall emotional welfare of the participants.

This type of programming requires a staff who can innovate and yet maintain the integrity of a structured environment. Group leaders must be able to recognize when specific activities are not appropriate or not well received either by the group or an individual. They must be able to modify activities to meet both group and individual needs on any given day. Specific techniques used in programming this kind of flexibility include altering the duration of an exercise or activity and activity can be changed from an individual to a group activity. Alternatively, the group's response can be used to facilitate the care of an individual.

The overall thrust of this kind of a program is to encourage participation in as normal a fashion as possible. This will vary from individual to individual and from time to time. The program goals of the FRC are stated as follows:

- to provide a day care program of stimulating, social, physical, and creative activities for elderly persons with Alzheimer's disease and related disorders within
an accepting and supportive environment and which are aimed at minimizing the loss of physical functioning, social isolation and inactivity and maximizing the potential of each unique individual; to provide respite care and support for the members of families caring for persons with Alzheimer's disease and related disorders; and to provide an alternative to institutionalization which will allow persons with Alzheimer's diseases and related disorders to remain in their own homes for as long as possible.

Program Activities

Each patient has individual goals which are present during staff meetings. The clients present mental status, functional evaluation, past preference and personal needs are taken into account. A balance is struck between passive and active situations. These objectives are then worked into the structure of the daily plan. A considerable effort goes into integrating all this into a plan for the group. No one is ever forced to participate. As a result two or three activities at a time may be required to meet the groups needs.

The daily schedule will be as follows:

Plan for the Day

7:30-9:30 a.m. Drop off for early arrivals; coffee and conversation

9:30-10:00 Arrivals by most participants; semi-
structured activities, including current events discussion, group music, games, continual work on individual arts and crafts projects. Orientation to the day.

10:00-11:00 Armchair exercise
11:00-11:30 Snack break-Toilet
11:30-12:30 Varied Structured Activity Period, options including outdoor physical activity, guest speakers, slide or video presentation and discussion, Center maintenance, arts and crafts projects. Expressive therapy.

12:30-1:15 Lunch
1:15-1:30 Toilet
1:30-2:30 Video, slides, arts & crafts
2:30-3:30 Music, arts & crafts, exercise
3:30-4:00 Snack
4:00-5:30 Departures, structured individual activities, small group activities

Expressive Therapy

A unique component of the Center's program is expressive therapy. The Center's clients, by definition, have diminished memory and decreased cognitive skills. For many participants, particularly those with Alzheimer's Disease, language is particularly affected. Through art, music, and movement participants are given an opportunity to express themselves. Thoughts and feelings which have been walled in by increasing impairment are given an avenue of communication. By using
AMILY RESPITE CENTER, INC.
STATEMENT OF REVENUE, EXPENSES, AND FUND BALANCES—CASH BASIS
FROM JULY 13, 1985 (DATE OF INCEPTION) TO JUNE 30, 1985

REVENUE

Donations
Grants and Large Donations $ 64,900
Scholarship Donations 5,025
Memorial Donations 598
Property Donations 4,800
General Donations 5,892
TOTAL DONATIONS 81,215

Other Revenue
Client Fees 14,107
Fundraising –Net of Expenses of $ 572 1,597
Other Income 604
TOTAL OTHER REVENUE 16,308

TOTAL REVENUE 97,523

EXPENSES

Program Services
Consummables 1,535
Consulting fees 5,749
Depreciation 26
Food 1,097
Inservices 82
Insurance 1,654
Moving Expenses 2,032
Rent 2,850
Printing, Postage and Publicity 669
Salaries 12,133
Start-up expenses 981
Taxes-Payroll 646
Telephone 643
TOTAL PROGRAM SERVICES EXPENSE 30,097

Supporting Services
General Administration
Legal and Accounting 1,810
Office Expense 793
Salaries 7,508
Start-Up Expenses 245
Taxes-Payroll 400
TOTAL GENERAL ADMINISTRATION EXPENSES 10,756

Fundraising 3,169
TOTAL SUPPORTING SERVICES EXPENSES 13,925

TOTAL EXPENSES 44,022

EXCESS OF REVENUE OVER EXPENSES 53,501

BEGINNING FUND BALANCES 0

ENDING FUND BALANCES $ 53,501

See accompanying notes and accountant's report.
alternative cognitive input the isolation of these individuals is lessened. The art works produced are a way of monitoring the progress of the client during their stay in the Center. There is also a certain level of satisfaction and pleasure in the clients as they construct something individually or contribute to the work of the group. Currently full group art therapy sessions are held four times a week. If funding becomes available individual sessions are scheduled to begin this Spring.

EVALUATION:

The Family Respite Center has served participants for sixteen months and it has successfully achieved its primary goal of providing respite to the families of demented adults late in the stages of their disease. We have successfully managed those with a history of wandering and aggression and we have developed strategies to deal with incontinence. More importantly, by applying the theory of Milieu Therapy we have been able to program activities for the severely demented, provide education and support for their families and help our participants remain in their home and their community.

Our first Annual Report is included in the Appendix (Appendix B) and shows our progress during the first year. Summarily, it shows that we attained our program goals but have not yet reached our business goal of serving twenty clients per day, five days a week.

From a business point of view, the first year of the Center cost $53,501.48. This was well within the budget ($68,000) but only reflects 10 months of business and less than full
enrollment. (See Fig. 2) This translates into an average cost per day of $61.43. The cost was for an average of 5.38 clients per day. These figures are well above the ultimate cost of 22.80 per day but reflect start up and slow growth. By June, (the end of our first fiscal year), the average attendance was up 8.1 participant per day and by October this figure had reached 12.8 per day. By December, the cost of operating to $35 a day. Based on the first years' actual expenses, the projections for next year show that 22,80 is still an achievable goal for 20 participants per day. However, this figure does not reflect accepting indigent participants and scholarship funds will still have to be raised to continue caring for those who cannot pay for their care. By December of 1985 we noted that we had lost 50% of our population due to death. In part, this was just a manifestation of some well known statistics from the state of California 25 years ago. There is a 50% one to two year mortality in patients who were institutionalized for dementia at that time. Since our facility was, to a large extent an alternative to institutionalization, it was quite clear that this was not unexpected and that we were in fact fulfilling our commitment to provide an alternative to nursing home placement.

Whether or not this Center can succeed from a business point of view remains to be seen and hinges on reaching capacity. Several issues surround the Center's ability to achieve a "full hours" status:

1. Community Awareness Of Program

Adult Day Care is a relatively new concept itself and is gaining acceptance as an alternative to nursing home care slowly.
Dementia specific day care is even newer and comes when society at large is just becoming familiar with dementias as illnesses, much less beginning to consider ways to help those individuals afflicted with severe memory loss.

2. Individual's Perceptions Of The Center

Families who utilize the Center at this point are very knowledgeable about Alzheimer's type illnesses, aware of their options for care and understand that the program has a therapeutic effect for their loved one. Caregivers who bring their relatives here are also most eager to avoid nursing home placement and are dedicated to caring for their relative in the community.

3. Referral Resources

Besides general community acceptance, acceptance of this type of Center by health professionals, and psycho-social community professionals is a slow process. Learning which demented people to refer and reassuring families about our services is slow in coming. Viewing our Center as "filling in the gap" between established day care centers and institutions has not been an easy concept to convey.

Lack of Additional Services

The Center has traditionally offered "no frills" services in an attempt to reach a cost effective status where Center costs are covered by Center revenue. There is no transportation or other services which are offered by other Centers above and beyond basic day care. The specialty is programming for the demented and being able to meet their needs.
in a therapeutic way. Because of our "shoe string" budget we cannot compete with the glitz of other centers. Although participants are generally not affected by these extras, families may perceive them as desirable for their loved ones. Clients who may be more appropriately served in our Center go to others because the family is attracted by services beyond the basics. Whether or not this Center presents a viable alternative as an independent service, replicable by others remains a question. What can be answered at this time is the effectiveness of this type of service for the severely demented. These individuals can be cared for outside of a nursing home at a cost less than nursing home placement would cost. Groups of severely demented individuals can function at a good level and individuals in late stages can achieve satisfaction from being part of a therapeutic milieu. The Center's presence in the community has had an effect greater than the provision of daycare for its own participants. It has become an educational site for professionals, educators, researchers and families to observe and learn techniques and philosophic guidelines for caregiving. It seems also to have had an effect on other adult day care centers who are now accepting incontinent participants. One area program has seen merit in special programming for the demented and now has special tracts within its center. One tract is the more cognitively impaired. Area nursing homes have approached the Center looking for guidance in starting special Alzheimer's units. Many in these groups are beginning to think about the special needs of the cognitively impaired and how best to meet those needs in a
therapeutic way.

Objective testing to demonstrate improvements or lack of decline in function, participation in ADLS and life satisfaction care needed for evaluation of this Center. If the concept of independent center is not viable, what features in its programming can be extracted and applied in other settings? How to grow and build on existing knowledge of milieu therapy is an important question.
PLAN
FOR THE IMPLEMENTATION
OF AN
ADULT RESPITE DAY CARE CENTER

Sponsored by
Alzheimer's Disease and Related Disorders Association
Northern Virginia Chapter

Prepared under contract with
Robert R. Aptekar, President
North Star Planning and Management
McLean, Virginia
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I. BACKGROUND

Nancy L. Mace and Peter V. Rabins co-authored the book, The 36-Hour Day in 1981. It provides a guide for families of persons with Alzheimer's disease. The following sections draw extensively on their work.¹

A. Alzheimer's Disease

While 85 percent of all older adults live out their lives with their mental abilities intact, the remaining 15 percent suffer from progressive memory loss, intellectual impairment, and the inability to care for themselves.² These symptoms comprise the clinical picture of dementia.

There are many causes of dementia, some of which, like thyroid disease, can be treated or cured. However, most dementias are progressive and irreversible. Alzheimer's disease, named after the German physician who first described the condition in 1907, accounts for 50 percent of irreversible dementia and is the fourth leading cause of death in older adults.³

The symptoms of Alzheimer's disease usually are a gradual, and sometimes imperceptible, decline in many areas of intellectual abilities and an accompanying physical decline. This neurologic disease destroys brain cells in an otherwise healthy person, and it is unknown as to what causes the disease or who is at risk for getting it.

Early in the illness only memory may be noticeably impaired. Personality may change or depression may appear. Later, impairment in both language and motor abilities are seen. At first, the person may be unable to find the right word or the wrong word may be used. Gradually, he/she will be unable to express him/herself and will be unable to make sense of the environment. An inability to understand explanations may occur, and previously easy tasks will become difficult. Eventually, Alzheimer's victims lose their ability to care for themselves, and need help with eating, dressing and walking.
Behavior problems often accompany the loss of intellect. Some victims wander and get lost, some become hostile and abusive and have uncharacteristic outbursts of anger, and others talk and babble incessantly. Late in the illness, they become incontinent and need constant supervision.

The course of the disease is variable. While some victims live only a year or two after diagnosis, others live ten years or longer.

There is no known cure for Alzheimer's disease, although research has increased in recent years. Researchers have found that the brain cells of Alzheimer's victims may harbor abnormally large numbers of senile plaques or neurofibrillary tangles, or there may be a loss of nerve cells. Diagnoses are made on the basis of the types of symptoms, the way the symptoms progress over time, the absence of any other cause for the condition, and a compatible CAT scan. However, a final diagnosis can only be made after a brain biopsy.

The magnitude of the problem of Alzheimer's disease and other dementias cannot be overlooked. Society is "growing older" and people who suffer from dementias are living longer with these diseases. Currently, over half of all nursing home beds are occupied by dementia victims, and Dr. David Drachman projects that one out of every three adults whose parents survive past the age of 65 will be involved in their care because of dementia.4

The disease destroys its victims little by little, and causes enormous emotional and financial problems for families and society. While researchers are vigorously looking for the causes and cures for this silent epidemic, we are faced with real problems in providing care and help in day-to-day living for over 1.5 million Americans.

B. Living with a Person with Alzheimer's Disease

Living with a beloved family member who has an incurable, deteriorating, chronic dementia places a heavy burden on the
rest of the family. This is not to say that love, caring, joys, and pleasures cannot, and do not, remain. Many people discover a sense of pride in learning to cope with difficult situations. Many families rediscover one another as they work together in caring for the ill member. However, for our purposes we will focus only on the changes required and the stresses incurred by family members as they learn to readjust their lives to meet the needs of their loved one.

A wide variety of new feelings can be expected to be experienced by all members as they undertake to care for an Alzheimer's victim. Sadness, anger, helplessness, guilt, discouragement, loneliness, depression, grief, and exhaustion are all common and understandable.

Roles, responsibilities, and expectations within the family unit change when one member becomes ill with dementia. Often for the first time, wives must learn to maintain family finances, husbands must learn to accept household maintenance chores. Children are asked to grow up quickly and accept new responsibilities. The members of the family may need a new leader or "head of the household."

In adjusting to these new roles/responsibilities and the new feelings encountered, family members themselves often change. A spouse often can feel increased pressure at not having someone with whom to share family responsibilities. Children may find the role-reversal caused by the need to care for a parent a difficult adjustment. The knowledge that love relationships will never be the same will be difficult to accept. Outside interests are curtailed and time for hobbies or other recreational endeavors is lost. A philosophy of life and what's really important also changes.

C. Family Caregiving

Yet, in spite of all the stresses placed on family members, almost all families accept the responsibility to care for their ill loved one for as long as possible. The commonly held belief
that families "dump" their sick elderly members into nursing homes or other institutions is just not true. While over $20 billion are spent on long-term care by public authorities and approximately $10 billion a year by private individuals, the greatest expenditures are borne by families who take care of frail members at home for as long as possible (a cost difficult to pinpoint but estimated at $38.2 billion a year by the U.S. Comptroller General). 5

Interestingly, the National Council on Social Welfare suggests that "more people are placed into nursing homes because family resources and funds are exhausted than due to a change and deterioration of health." 6

They go on to attest that "about three-fourths of all impaired adults are helped by their families, and not by a formal program. Some studies show that the elderly use their family, friends and neighbors five times as often as an organized servico or agency." 7

For every person now in a long-term care institution, there are at least two people with similar disabilities back home, most of them cared for predominately by family members. Between 60 and 85 percent of the care received by the impaired elderly is provided by relatives and friends who are not compensated for their time. 8 According to a 1978 HEW Task Force, between 3.6 and 7.8 million persons received long-term care services from families and friends, one-third of them needing constant, rather than partial or intermittent, care. 9

Perhaps it is the strain caused by the need for constant supervision that causes the most stress on family members. Families report that their greatest problems are in coping with the mental conditions of their loved ones, as opposed to their physical impairments. 10 Those people who have had the actual experience of providing long-term care to a family member do not say that it is financial assistance that is their primary need, but rather it is community support services, including help for their disabled loved one and relief for those that are providing the constant care. 11
D. **Respite Day Care**

When examining the support needs and interests of family caregivers of persons with Alzheimer's disease and related disorders, several concerns become apparent: 1) To obtain a support service which will provide the best quality assistance to their ill loved one; 2) To allow their loved one to remain in their own home for as long as possible, rather than prematurely moving into an institutional setting before skilled nursing care is required; and 3) To provide respite and support for the family caregivers in order to allow the time necessary to conduct personal business and social affairs, as well as to recoup the energies required for supporting their ill family member. An adult respite day care center provides for all these needs and interests.

Day care is a unique service because it can meet the long-term needs of those seeking service while also taking into account individual differences. It differs from outpatient services and senior centers in several important aspects: services are tailored specifically for each participant; each service has a therapeutic objective; each day is planned for each individual; and activities are not chosen at random by the participant.\(^\text{12}\)

Surveys of elderly people have found that the great majority prefer to remain in their own homes for as long as possible rather than enter other residential institutions. Robert Butler, former head of the National Institute on Aging, describes the response as coming from an understanding that "home is extraordinarily significant to many older persons. It is their identity, a place where things are familiar and relatively unchanging."\(^\text{13}\) This tenacity to remain at home is probably associated with a fear of loss of dignity and independence, contact with loved ones, and a fear of dying. And although loved ones share this interest, some, lacking the support required within the community, prematurely place their ill member in an institutional facility before skilled nursing care is required. The National Conference on Social Welfare (NCSW) reports that
"as much as 20% to 40% of the nursing home population would be cared for at less intensive levels if adequate community-based care was available." The American Association of Retired Persons suggests that "the goal should be to get the institutionalized elderly to lower and more appropriate levels of care where possible." They go on to say that "publicly and privately supported patients in nursing homes who would be able to reside in their communities if proper support services were available and accessible ought to be assisted in doing so." Further, they note that "the family currently receives little assistance in caring for dependent elderly persons in their own homes." And the NCSW concludes that "adult day care centers offer the disabled person the opportunity to continue living at home while providing supervision during the day, and at savings . . . over the cost of nursing home care."

A recent study of 450 day care centers that serve persons with Alzheimer's disease and related disorders revealed that the majority served at least a "few" demented adults, and that 5 percent of the centers served primarily the "seriously" demented adult. For this latter group, the programs were able to provide service successfully up to only weeks before death. In on-site visits to these facilities, the researcher found that the social opportunities provided to the clients were "good for them," "allowed them to make friends," and gave them a chance "to benefit from social interaction."

Relief through a day care program for family members providing full time care and support to a loved one with Alzheimer's disease not only can provide the ill person with a positive experience, but also will do much to allow that person to remain in their own home for a longer period of time (therefore, also providing for a cost-effective alternative to institutional care). The provision of 1-3 days per week of day
care can allow the family caregiver time to take care of business or maintain some social activities outside the home, and do much to provide a period of rest from the constant demand for support. And for the family, this time apart can make the time together more pleasant.
II. THE NEEDS FOR ADULT RESPITE DAY CARE FOR PERSONS WITH ALZHEIMER'S DISEASE IN NORTHERN VIRGINIA

A. Number of Elderly in Area

As reported by the Northern Virginia Planning District, there are approximately 56,000 adults over 65 years of age currently residing in the Northern Virginia area. These consist of the following:

- Fairfax County: 28,000
- Arlington: 18,000
- Alexandria: 10,000

Total 56,000

B. Number of Persons with Alzheimer's Disease and Related Disorders in Area

The National Institutes of Health in their 1981 publication, "The Dementias--Hope Through Research," reports that "5% of the U.S. population 65 or older is severely demented. Another 10% may be mildly to moderately impaired." It is from this group that our program will draw its clients. If we consider these figures for the Northern Virginia over 65 population, we note that 8,400 persons are eligible for the proposed adult respite day care center. This breaks down as follows:

- Fairfax County: 4,200
- Arlington: 2,700
- Alexandria: 1,500

Total 8,400

C. Currently Operating Adult Day Care Programs in Area

Northern Virginia has four operating adult day care centers. Below are cited the client capacities and current enrollment.
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<tr>
<th></th>
<th>Capacity Per Day</th>
<th>Current Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annandale Center (Fairfax)</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>Madison Center (Arlington)</td>
<td>35</td>
<td>60</td>
</tr>
<tr>
<td>Woodbine Convalescent Center (Alexandria)</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>Loewood</td>
<td>50</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>135</strong></td>
<td><strong>144</strong></td>
</tr>
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These facilities all provide service to a few persons with Alzheimer’s disease. If we can assume that the existing programs serve 10 percent of the mild to moderately impaired in combination, perhaps 14-15 persons with Alzheimer’s disease are currently receiving care. However, as the disease progresses and behaviors such as wandering, agitation, and incontinence become more pronounced, these facilities cannot adequately provide proper care.

It is clear that the currently operating day care programs, while beginning to address the need are set up to serve the mentally intact and, therefore, do not have the capacity to serve those who exhibit the behaviors associated with the later stages of Alzheimer’s disease and related disorders. Further, as reported by Sands, and reiterated by Mace, homogeneity of the participants is a key factor in the success of day care programs for persons with Alzheimer’s disease and related disorders.

D. **Unmet Need in Area**

Many of the people in need are known to the Alzheimer’s Disease and Related Disorders Association (ADRDA) Northern Virginia Chapter. The availability of such a new support program can easily be made known to them through the Association's mailing list. In addition, referrals from the four currently operating centers would be welcomed.
In responding to the requests of several of its members to explore the feasibility of creating such a program, ADRDA/NOVA distributed a questionnaire at its September 1983 monthly meeting (See Appendix A.) Twenty-two responses were submitted from those in attendance. The results are as follows:

- 13 of the 22 respondents said they currently needed and would use such a facility if it were available.
- 8 respondents requested care 4-6 days a week; 4 specified their interest in care for 1-3 days a week.
- 10 respondents requested full-day service; 3 others wanted half-day care.
- Respondents suggested a willingness to pay between $3-4/hour for the receipt of such care.
- 15 offered to provide some form of volunteer services to defray the cost of care.
- Only 2 respondents requested assistance with transportation, whereas 10 others said they could manage their own.
- And, 15 of the respondents expressed an interest in participating in the planning of the new program.

E. Advice from Others

With these needs in mind, the ADRDA chapter sought the advice of other groups throughout the country who have had similar experiences in creating and providing day care services for persons with Alzheimer's disease and related disorders. Visits were made to the Burke Rehabilitation Center in White Plains, New York, the Judson Park Day Care Center in Cleveland, and the Harbor Area Adult Day Care Center in Costa Mesa, California, where the President and a member of the Respite Day Care Committee attended a three-day workshop in creating a day care program for persons with Alzheimer's disease and related disorders.
F. Conclusion

Based upon our assessment of the current need for adult respite day care for persons with Alzheimer's disease and related disorders and their families in Northern Virginia, as well as the advice obtained from others who have had similar experiences, we have determined that an initial client load of 3-5 per week, growing to 20-25 persons by the end of the sixth month is most realistic. The program to be provided for these persons in need is described below.
III. THE PROGRAM

Proposed below is the creation of an Adult Respite Day Care Center for families of persons with Alzheimer's disease and related disorders living in Northern Virginia. Many of the ideas used to formulate this section were obtained from the Harbor Area Adult Day Care Center (Costa Mesa, California), Dan Sands, Ph.D., Director.23

A. Program Philosophy

The essential philosophic assumption upon which the day care center is based is that the total environment of the program is itself a major factor which needs to be developed and used in a manner to provide a climate of positive support for all those operating within it. This philosophy, used as the basis of the successfully operating Harbor Area Center, recognizes that each of the environmental components—the activities, the physical setting, the staff, and the participants themselves—have the potential for providing a positive (or negative) impact on the success of the program.

One's social and physical environments have a profound influence on behavior, attitude, and self-image. Coons describes this theory as "milieu therapy."24 The expectations of those around us, the limits placed on us by our physical setting, the rules which govern us, and the activities in which we engage (or don't engage) determine much of our behavior, how we view ourselves and our world. Living in a barren setting lacking in challenging activities and social interactions produces a defeatist attitude, isolation, and a poor image of ourselves. Conversely, an environment rich enough to provide a range of activities and a variety of positive social experiences, allows us to maximize our potential. We expect to create such an environment, one which provides this opportunity through challenging activities, positive social experiences, and a comforting physical setting.

Our philosophy recognizes that program participants will benefit most when:

- The program environment offers opportunities and experiences which allow participants to maximize their potential;
The program is designed to provide a broad range of structured, and individualized, experiences which place positive, realistic expectations on all participants; and

The program provides a homogeneous grouping of individuals, which allow each person to achieve their own potential level of independence in accordance with their own unique set of needs.

The philosophy leads us further to the following understanding of the rights of program participants:

- No participant shall be denied service due to gender, race, creed, or economic status.

- The program shall provide adequate and varied activities which maximize potential and encourage self-care.

- Participants and their families will be closely involved in developing their program activity schedule.

- The program will be provided in a clean, sanitary environment which is safe and in good repair.

- Participant records shall be considered confidential and shall only be open to staff on a need-to-know basis. Information about participants shall not be released without written approval.

- Participants have the right to voice grievances without reprisals.

The implementation of this philosophy within the program itself is the challenge we have set before us.

B. Program Goals

Based upon our program philosophy, we have developed a set of program goals. These broad statements of intent are designed
to provide an overall long-range perspective to guide and focus the program's direction. Our goals are stated as follows:

- To provide a day care program of stimulating, social, physical, and creative activities to elderly persons with Alzheimer's disease and related disorders within an accepting and supportive environment and which are aimed at minimizing the loss of physical functioning, social isolation and inactivity and maximizing the potential of each unique individual;

- To provide respite care and support for the members of families caring for persons with Alzheimer's disease and related disorders; and

- To provide an alternative to institutionalization which will allow persons with Alzheimer's disease and related disorders to remain in their own homes for as long as possible.

C. Admissions

1. Policy

Any person with Alzheimer's disease or related disorder residing in the Northern Virginia area will be eligible to participate in the Adult Respite Day Care Program if he/she meets the following criteria:

- The type of support and supervision required can be provided by the Center;

- The participant is compatible with the other program participants; and

- The needs of the participant can be met by the program within the limitations and restrictions of the program's license to operate.
2. **Procedures**

The following procedural steps will be taken to admit a new program participant.

a. A review of the initial referral will be made, and if it is not from the participant's physician, an Approval for Participation form will be requested. (See Appendix B.)

b. An appointment with the potential participant and family caregiver will be scheduled for an initial interview and screening. At this time the program will be explained, fees discussed, and, if the participant and family are interested, a Release of Information and Initial Referral Sheet (Appendix C) will be completed. In addition, a Client Record Data Base form (Appendix D) will be set up, and Emergency Procedure form (Appendix E) completed, and the Patient Interest Profile (Appendix F) and Activities of Daily Living form (Appendix G) sent home for completion prior to entry into the program.

c. When all of the entry forms are completed, the staff will meet to review the materials and ascertain whether the program can provide the support required, and whether the potential participant will fit appropriately into the program.

d. An affirmative decision to admit a new participant will lead the Center Director to assign staff based upon the participant's needs. The staff will observe the new participant while in the program for two weeks to become more familiar with his/her needs and interests.

e. After two weeks of observation, an Individualized Program Plan will be developed based on the initial assessment interview, materials reviewed, and observation. The Plan will contain measurable program objectives in each of the following areas:
Communication;

Physical and medical;

Social;

Program Activities;

Ambulation; and

Self-care.

A specific program and schedule will be built around the Individualized Program Plan objectives which, in combination, will be designed to maximize the potential of the participants. This step completes the admission process.

D. Program Activities

Individualized Program Plan objectives will be achieved through participation in a stable, structured program built around a daily schedule of activities which also will allow for necessary individual variations and choices. The program will be designed to meet the participants basic human needs, including:

• The need for recognition;

• Maintenance of self-esteem;

• The development of meaningful relationships;

• Activities which are structured, yet varied enough to provide for individual choices; and

• Personal space.

Recognition will be facilitated by encouraging clients to participate actively in the program and then enthusiastically acknowledging their accomplishments. Staff efforts to maximize independence will be provided through participant involvement in various activities (e.g., preparing snacks, setting tables) which enhance self-esteem. Small group activities will provide the opportunity for cohesiveness, developing relationships and encouraging mutual help. The expected variability in ability/
disability among participants should allow almost everyone to be at least occasionally of help to someone else. The flexibility of activities should allow each participant to exercise choices and control over his/her own environment.

The daily schedule will be as follows:

**Plan for the Day**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>7:30- 9:00 a.m.</td>
<td>Drop off for early arrivals; coffee and conversation</td>
</tr>
<tr>
<td>9:00-10:00</td>
<td>Arrivals by most participants; semi-structured activities, including current events discussion, group music, games, continual work on individual arts and crafts projects. Orientation to the day.</td>
</tr>
<tr>
<td>10:00-10:30</td>
<td>Armchair exercise</td>
</tr>
<tr>
<td>10:30-11:00</td>
<td>Snack break - Toilet</td>
</tr>
<tr>
<td>11:00-12:30</td>
<td>Varied Structured Activity Period, options including physical therapy, occupational therapy, speech and communication, craft projects, discussion group on topic of mutual interest, counseling, gardening, table games, food preparation, music and dance.</td>
</tr>
<tr>
<td>12:30- 1:30 p.m.</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:30- 3:00</td>
<td>Varied Structured Activity Period, options including outdoor physical activity, guest speakers, slide or video presentation and discussion, Center maintenance, arts and crafts projects.</td>
</tr>
<tr>
<td>3:00- 3:30</td>
<td>Snack break - Toilet</td>
</tr>
<tr>
<td>3:30- 4:30</td>
<td>Special therapies -- art, dance, music, drama</td>
</tr>
<tr>
<td>4:30- 5:00</td>
<td>Support groups/discussion</td>
</tr>
<tr>
<td>5:00- 5:15</td>
<td>Wrap up</td>
</tr>
<tr>
<td>5:15- 5:45</td>
<td>Departure; some structured individual activities, TV, nap until pick up</td>
</tr>
</tbody>
</table>

Each of these periods is discussed below.
• **Drop off/Arrival**

Strict adherence to a designated arrival time, whether early (7:30-9:00) or regular (9:00) will be necessary because a participant's adaptation to the program often will be contingent on becoming a regular group member. Participants will be scheduled, and expected to attend on regular days of the week. Attendance will be taken at 9:30 and if someone is absent, the participant's home will be called. (Obviously, family members will be advised to call in advance when an absence is expected.)

A staff member will be designated to greet all participants upon arrival. This will be an excellent time for gathering and transmitting information. This time may also allow for learning about changes in medications, personnel at home, concerns and illnesses. A few words at this time may reveal a problem, or a triumph, at home that may affect the patient's attitude or mood, or be used as an encouragement in the program.

Coats and hats will be hung in a separate area and out of sight of the participants to avoid requests for going home.

During this initial time period, participants will be reminded of why they are at the Center and what is planned for the day. This orientation exercise will be the foundation for the day and never will be omitted. Each staff person and participant will be reintroduced each morning. Name tags and photographs will be used. A brief factual point about each person will be included in the introductions (e.g., where from, name of article of clothing) to help identify the person.

A large portable chalkboard with date, day, month, year, name and address of the Center written in large letters will be prominently displayed to assist participation in orienting to time and place. Discussion of the season, weather, holidays, etc. will also be included.
Next, the daily schedule of activities will be discussed. It will also be written on a blackboard for all to see.

Perception activities to stimulate all the senses also will be included during the initial daily session. These may include art, music, horticulture, cooking, games, poetry, sports, and storytelling. This period also will be useful for observing a participant's decline. Increased apraxia, loss of context, disorientation to person, place or time may be evident and require a change in the Individualized Program Plan.

• **Exercise**

Exercise and movement have positive effects on muscle tone, maintain range of motion, and help maintain alertness. It stimulates memory. Rhythmic clapping and stamping are good warm-ups. With a staff person demonstrating, participants will be asked to move their heads, necks, arms, and fingers. Appendix H offers a list of exercises. Props such as balls, dowels, or musical chimes will be used.

• **Snacks/Lunch - Toileting**

Snacks and lunch will not be used merely as a break in the program, but rather as an opportunity to provide nourishment, observe capacities for using table utensils, encourage good manners, and stimulate conversation. A staff person will be assigned to eat with each table of participants to encourage conversation and interrupt potential crisis.

Individual meals will be prepared off-site and brought in fresh each day. Dietary restrictions will be followed.

Snacks/lunch will be followed by a brief (15-minute) rest period to allow for clearing tables and toileting.
participants. These will be the only unstructured times for participants during the day.

A word on toileting and incontinence. Some participants will need no reminders to go to the bathroom, some will need verbal clues, while others will require full assistance. Families will be asked to provide changes of clothing or incontinence devices as required. Toilet needs will be maintained on a written schedule and posted inconspicuously for the use of all staff. Quiet reminders, where necessary, will be made. All staff will be expected to assist in this activity. "Incontinence in persons with dementia is usually not the result of a neurological disease which has made the person unaware of bowel and bladder control. Some of these behaviors can be modified." 25 Why a person is incontinent must be investigated. Sometimes it is due to disorientation—the person can't find the bathroom or is not able to communicate his/her needs. For others, incontinence is a means of expressing anger. A regular toilet schedule does much to manage a person who has become unaware or unable to control his/her bladder and bowel functions. Also, it is possible to retrain many people. Both of these techniques will be used to minimize the embarrassment felt even by those with severe intellectual loss. However, whenever participants become soiled, they will be cleaned.

• Varied Structured Activity (2 Periods)/Special Therapies

The two structured activity periods, as well as the special therapies session, will be provided in a manner designed to obtain a balance between too much and too little structure. Confusion and dependence are the two extremes. The idea is to provide enough structure to reduce confusion, and, at the same time, encourage independence.

Balance is the key to the use of activities, as well.
On the one hand, participation in an activity can be seen as making demands or expectations that can create feelings of pressure; on the other hand, not enough participation in activities can result in boredom or loss of interest. Activity is not to be used as an end in and of itself, but rather as a therapeutic tool. The process is more important than the product. Activities, and participation, will be designed to meet individual needs. For some participants, coming to the Center itself might be enough; for others, special challenges will be important. Appendix I provides some guidance on "Planning an Activity." Appendix J offers "Guidelines for Teaching Older Adults," both of which were developed by the Costa Mesa Center.

Several other relevant guidance materials for conducting varied activities also have been developed by the Harbor Area Day Care Center. These are found as "Craft Instructions," Appendix K; "Facilitating Techniques," Appendix L; "Feedback," Appendix M; and "How to Talk with Participants about Sensitive Subjects," Appendix N.

Depending upon the needs of the participants, consideration will be given to the use of homogeneous groupings. If, for example, participants exhibit a wide range of word-finding difficulties and language deficits, three groups (one stressing non-verbal activity, one for the disoriented/confused but possessing some verbal skills, and a third group for those with only minor cognitive impairments) will be created. If only minor variations are found, groupings may not be appropriate.

The use of art, dance, music, and drama will provide a wide range of opportunities for non-verbal as well as verbal expression. As therapy, they all have proven to be very successful. All will be used within the period devoted to these activities.
**Support Group/Discussion**

Persons with Alzheimer's disease and related disorders are usually eager to discuss their disabilities in a group. Led by a competently trained and experienced professional, such support groups can prove to be very useful. A number of topics can be expected to be discussed. These may include group dynamics, the behavior of an individual in the group, and personal problems. The unique problem of Alzheimer's disease can be expected to be a central topic.

The sessions will be held in small groups around a table. Experience indicates that participants can be expected to discuss themes such as: 1) the cause of these new difficulties; 2) loss—of ability to drive, friends, and level of independence; 3) the difficulty in word-finding; and 4) role reversal due to the growing level of dependency.

The staff-participant relationship will be used to facilitate discussion. Helping to identify the problem, clarifying the staff role as a helper, evaluating the nature of the concern (crisis or chronic), and mobilizing resources (family, friends, agencies) will be the process used by the group leader.

**Wrap-up/Departure**

At the end of the day, the day's activities will be summarized for the whole group. The activity schedule on the bulletin board will be used for orientation. Participants will be reminded they are going home and who will be picking them up. Relaxing individual activities will be available while they wait for their pick up. The departure time will also be used to exchange information with family members, as well as share with them how the participant did during the course of the day.
E. Record Keeping and the Tracking of Participant Progress

Some records are necessary and useful in managing the day care program. In addition to those forms cited in the Admissions section above, the following informational materials will also be collected.

- The name and attendance record of each participant;
- A list of the participant's immediate family members and personal physician, with phone numbers;
- A personal statement by the caregiver of the participant's problems and symptoms;
- A list of each participant's current medications, including those which may be given during the day. (A designated place in the Center will be used to note the name, dosage, and time for receiving medications given at the Center); and
- A list of relatives in the form of a family tree to help identify obscure references in a participant's conversation.

The tracking of participant progress will be formulated around the Individualized Program Plan referred to above. In addition to the data obtained at admission (described in Admissions section), other baseline information will be obtained through the use of a standardized rating scale which measures the degree of disfunction due to intellectual loss on program participants and their families. Examples of these, provided by the Harbor Area Center, include the "Behavior Rating Scale," (Appendix O) and the "Burden Interview" (Appendix P). Observation of the participant's behavior during the first two weeks also will be critical. Appendix O suggests a means of recording the results of the observations.

After completing the initial assessment, staff will develop measurable objectives around key goal areas. The following
"List of Treatment Goals," provided by the Long Beach, California Senior Day Treatment Center is exemplary.

List of Treatment Goals

I. Physical/Functional
   1. maintain/improve health status
   2. improve diet
   3. improve self-care
   4. increase ADL skills
   5. increase independence

II. Cognitive
   1. increase sensory stimulation
   2. improve reality testing
   3. increase utilization of cognitive functions
   4. increase intellectual/cognitive stimulation

III. Emotional
   1. decrease egocentrism
   2. increase appropriate expression of feelings
   3. increase feelings of self-worth/self-esteem
   4. improve coping skills
   5. reduce depression
   6. reduce paranoid ideation

IV. Social
   1. decrease isolation
   2. increase communication skills
   3. improve interpersonal relationships
   4. improve family relations
   5. increase social skills
   6. increase utilization of social resources/supportive services
   7. increase leisure skills
With the Plan developed, staff will then track participant progress toward the achievement of each objective. A daily notation file will be used for each participant. Support group notes will be kept. Other relevant experiences will be recorded. Routine progress notes will be written every two weeks to summarize level of functioning, changes in behavior, and weight/pulse/blood pressure readings. A monthly staff meeting will be scheduled to review formally the progress of each participant, with objectives updated, as appropriate.

The involvement of both the participant and family caregiver in the Individualized Program Planning process is critical. In addition to regularly scheduled meetings with family caregivers, activities of the Center will be made known through a newsletter. It will be sent to family caregivers and will include the monthly calendar of meals and special activities and outings. It should prove useful in augmenting conversation about Center activities.

It should also be noted that the testing of participants at 3-6-12-month intervals on those standardized tests/scales used for the initial assessment should provide valuable evaluative data for furthering the work of the Center and the sponsoring agency.
IV. STAFFING

A. General Qualifications

In recruiting staff for the Adult Respite Day Care Center, a number of qualifications must be considered. The applicant's concept of the position must be carefully reviewed. He/she must understand not only the work involved, but the level of physical and emotional stamina required. And, all employees must meet the medical requirements of the Commonwealth of Virginia.

All job finalists who have not had similar previous experiences will be asked to spend a day working in the program (or a similar program prior to this Center's initiation). This will provide an opportunity to observe the applicant's willingness: 1) to clean up and dress incontinent people; 2) to hand feed an entire meal; 3) to repeat instructions and tasks continually; 4) to rotate assignments; and 5) to comprehend and accept that two-way communication may never be established completely.

An uneducated applicant may be as effective as one with a graduate degree. Experience working with similar types of participants is considered as most valuable. Applicants must show evidence of flexibility, i.e., the ability to change directions and responsibilities quickly. Applicants must understand that working with program participants is difficult, in part, due to their mercurial nature, and the difficulty in understanding them. The job can be dirty, exhausting and demanding. Applicants must understand that participants will not get better because of their most sincere efforts. It clearly is not a job for everyone, no matter how well trained and educated.

Yet, despite the difficulties, applicants should be aware of the many satisfactions and rewards that come from this type of employment.

The response of a person with dementia to an interested and caring individual is remarkable. The gratitude of families who are supported by caring staff is enormous. There is a reward in knowing that despite the inevitable consequences of progressive dementia, victims and their families are helped, family stability is maintained, and institutionalization is avoided, even for a brief period.
All new staff will be hired for a 90-day probationary period to assure both parties that a proper fit has been made.

B. Staffing Pattern

Based upon our examination of several dementia day care programs, most notably the Harbor Area Center of Costa Mesa, California, and the Burke Rehabilitation Center of White Plains, New York, we have determined that a staff-participant ratio of 1-5 will be appropriate to provide the program envisioned. The use of volunteers, predominately drawn from ADRDA members, will reduce the ratio to 1-3.

The following staffing pattern is proposed for serving a daily participant group of 25.

- Director (full time)
- Assistant Director (full time)
- Program Assistants (two, full time)
- Office Assistant (half time)
- General Assistant (half time)

C. Position Descriptions

1. Director

   - Requirements

The Director of the program will be a professional having received an advanced degree in nursing, social work, gerontology, or a related field, and possess direct experience working with persons with Alzheimer's disease and related disorders. Knowledge and experience working with family caregivers is also required. An ability to relate well with relevant community resources, agencies, and a voluntary board of directors is also an important skill to possess. Skill in the organizational development of a membership organization is preferred. The Director must also be capable of conducting support group sessions and providing staff training and supervision, as required.
Responsibilities

--Provide program and financial operating reports, as well as well-considered recommendations to the Board of Directors on a regular basis and as required;

--Provide orientation for new Board Members, as well as families of Center participants;

--Administer the Adult Respite Day Care Center within the policies set by the Board of Directors;

--Cosign checks with Board Treasurer and develop and maintain financial records, as necessary;

--Recruit, train, and supervise all program staff;

--Assist in fund raising by being available for public speaking and proposal development;

--Conduct support group sessions for program participants;

--Supervise the dispensing of medications in accordance with state and county regulations;

--Provide counseling for family caregivers, as needed;

--Maintain good relationships with other day care, health, and cooperative organizations;

--Provide a resource and operate as an advocate for persons with Alzheimer's disease and related disorders within the Northern Virginia area; and

--Perform other duties, as required.
2. **Assistant Director**

   **Requirements**

   The Assistant Director of the program will be a professional in a discipline complementary to that of the Director which may include nursing, social work, gerontology, or a related field. In addition, he/she will possess direct experience working with persons with Alzheimer's disease and related disorders. An expertise in programming and activities relevant to persons participating in the program is essential. Experience working in an adult day care center is preferred. Relevant program planning and development skills are essential. Experience in leading activity groups is important, as is staff supervision and training. Possessing an ability to maintain schedules, records, track and assess individual progress toward goal achievement are necessary skills.

   **Responsibilities**

   --Manage the daily activity program of the Center under the supervision of the Director;

   --Supervise and train all activity staff (paid and volunteer);

   --Conduct activity groups;

   --Conduct admissions process;

   --Create and maintain Individualized Program Plans for all program participants, making adjustments, in consultation with the Director and other staff, as required;

   --Assist in the dispensing of medications in accordance with state and county requirements;
--Consult and advise participants and family caregivers, as required; and

--Perform other duties, as assigned.

3. **Program Assistants (2)**

   • **Requirements**

     The two Program Assistants must possess either a degree in nursing, social work, gerontology, psychology, art therapy, recreational therapy, or a related field, or two years of successful experience in direct work with persons with Alzheimer's disease and related disorders, preferably both. Experience leading small activity groups in an adult day care center or similar setting is required. A range of specific skills in relevant activity areas, as well as the ability to be flexible in other areas, is important. The ability to work as a member of a team, under supervision, and maintain proper records is also necessary.

   • **Responsibilities**

     --Conduct activity groups, as assigned, under the supervision of the Assistant Director;

     --Participate in the development and management of participants' Individualized Program Plans;

     --Assist with daily activities such as drop off, snacks/lunch, exercise, wrap up and departure, as assigned;

     --Maintain records, as necessary; and

     --Perform other duties, as assigned.
4. Office Assistant (half time)

- **Requirements**

  The Office Assistant must be knowledgeable and personally familiar with the symptoms and characteristics of persons with Alzheimer's disease and related disorders and enjoy the benefits of providing support to them and their families. Experience working directly with persons with Alzheimer's disease and related disorders is preferred. Knowledge and successful experience in the full range of office skills (e.g., clerical, bookkeeping, record keeping, scheduling) are required. An ability to relate well to people and have flexibility is essential, as is the ability to work well in a team, under supervision.

- **Responsibilities**

  --Manage the Center office under the supervision of the Director;

  --Maintain office and participant records in an organized and confidential manner;

  --Maintain roster of daily participation of staff and participants;

  --Maintain financial records, including accounts receivable, payment of expenses, payroll and taxes;

  --Prepare other necessary office-related materials, upon request;

  --Assist with daily activities, such as drop off, snacks/lunch, wrap up and departure, as assigned; and

  --Perform other duties, as assigned.
5. **General Assistant (half time)**

- **Requirements**

  The General Assistant must be knowledgeable and personally familiar with the symptoms and characteristics of persons with Alzheimer's disease and related disorders and enjoy the benefits of providing support to them and their families. Experience working directly with persons with Alzheimer's disease and related disorders is preferred. A broad range of skills in program activity areas is essential to allow for flexible use in all areas of Center programming. An ability to relate well to people is essential, as is the ability to work well in a team, under supervision.

- **Responsibilities**

  --Assist with any, and all, aspects of the Center program, as assigned, under the supervision of the Director;

  --Conduct activity groups, as assigned, under the supervision of the Assistant Director;

  --Assist with daily activities, such as drop off, snacks/lunch, toileting, exercise, wrap up and departure, as assigned; and

  --Perform other duties, as assigned.

**D. Volunteers**

In order to allow for more individualized attention, supplementing personnel in the form of volunteers will be used to complement paid Center staff.

Recognizing that volunteers cannot be viewed as free labor or substitutes for paid staff, roles and responsibilities for them will be assigned only in non-essential areas. They will be viewed as luxuries and not as substitutes for necessities. They will be treated as staff members, with position descriptions outlining specific responsibilities developed
for each one. They will then be expected to carry out their assigned duties and receive supervision and training, in a manner similar to their paid counterparts. Also, as with paid staff, potential volunteers will be asked to spend a day in the program before a commitment is made.

The use of volunteers is considered a valuable experience for the program. They can add a freshness and variety to the Center through the specific skills and interests which they may possess.

The use of family caregivers as volunteers will be strongly considered. This group will be most familiar with the needs and interests of the program participants and be experienced, as caregivers, in working with persons with Alzheimer's disease and related disorders. An added benefit is the cross-fertilization of techniques used by staff, and those successfully used at home by the caregivers, each learning from the other, all to the benefit of the program participants. Further, a consistent support effort between home and Center will do much to assist in the achievement of the treatment goals.

In addition, volunteers will be recruited for non-caregiving roles such as cleaning, painting, transportation, slide shows, music, art, pet therapy, and wherever other unique skills could be provided to participants.

Three volunteers per day will be recruited to allow for enrichment of the program.

E. Staff Management

An evaluation and discussion of job performance between supervisor and staff member will be made every six months. The "Staff Evaluation" form used by the Harbor Area Center (Appendix R) will be considered as a format for such sessions.

In addition, a regular time will be allotted to in-service training for all staff and volunteers. Topics of mutual interest and need will be addressed.
V. FACILITY REQUIREMENTS

With the decision to create an Adult Respite Day Care Center comes the need to find suitable space for the program. In order for us to obtain the best facility which meets all the program needs, several factors must be examined. These have been grouped into the following areas: 1) licensing standards; 2) space considerations; 3) square footage needs; and 4) location. Each of these items is discussed below.

A. Licensing Standards

The information in this section comes from the Virginia Department of Welfare's Division of Licensing which is responsible for the care and protection of adults cared for on a regular basis outside of their own homes. Their jurisdiction includes adult day care centers. Their publication, "Standards and Regulations for Licensed Adult Day Care Centers," adopted in 1975 and amended in 1981, enunciates the standards which must be met by a facility in the Commonwealth of Virginia which is operating for profit. Currently, no licensing standards are required for non-profit operators, although consideration is being given to expanding the coverage of the standards to non-profit operators. What is important to note is that the State's involvement in these matters is predicated on "the care and protection" of vulnerable groups. Therefore, the standards set are minimal--those required to assure the necessary care and protection only. They do not have a legal basis for quality of the program itself beyond these minimal concerns. Therefore, with our interests beyond those of the licensing requirements, and recognizing the potential of our facility to eventually be required to obtain a license to operate, the facility will be voluntarily operated in full compliance with the Virginia licensing standards set
for such a facility. The most pertinent requirements are exerpted and included as Appendix S.

B. County Operating Permit

In addition to meeting the state requirements, there are those set by the County in which the facility is located. Consideration will be given to both Fairfax and Arlington Counties.

The beauty of the manner in which Fairfax County is organized is that it has developed a single procedure incorporating the requirements of several different offices. By submitting the required application to The Environmental Health Division of the Health Department, an applicant has only one agency with which to work. This office oversees the process of obtaining the required operating permit by forwarding copies of the submitted materials to the other public agency reviewing officials.

In Arlington County, the Office of Environmental Health also is the first place to contact. Their main concern is for food operations and the permit issued is a permit "to operate a food facility"—required even if meals are prepared elsewhere and brought to the Center. They (Mr. Glen Rutherford) advise that once a potential facility is selected that we draw up a "preliminary" set of plans which they will review with us. Such plans can be hand drawn to scale noting doors, kitchen, bathrooms, etc. At that time they will notify and advise us as to whether other govenrmental units will need to become involved. This will depend upon the changes required in the facility. Changes in plumbing, electrical, or moving a wall may require other governmental office reviews.

In Fairfax County two different roads may be taken depending upon whether a zoning variance is needed. Since the use of a facility for a different purpose requires at least a zoning variation, that road is most likely the one that will be required.
1. Obtaining a Zoning Variance

In Fairfax County the first concern is which category is most appropriate. The response to the letter (found as Appendix 'T') sent to Mr. Phillip Yates, Fairfax County Zoning Administrator, 10555 Main Street, Fairfax, VA 22050, will provide the answer as well as the specific requirements and steps to obtain the variance. Four months from the time of application must be expected until the decision on the variance request is made. Costs may be incurred if this process is required, including $300 for a public hearing, plus engineering fees for the development of a certified plat. (It is possible our selected facility will already have a plat and, therefore, not require these extra costs.)

In Arlington County Mr. Caffo, the Zoning Administrator, suggests 2-3 months may be required (advertising and posting notices for one or two public hearings) to obtain the necessary Use Permit. Such a permit is required for any facility with more than 25 people. A map of the County designating the current zoning is available from the Zoning Commission in the Arlington Courthouse. A C-2 "General Commercial" designation is the probable category. The County Board will make its decision on the zoning variance request at the public hearing.

2. Obtaining an Operating Permit

In Fairfax, if no zoning variance is needed, then the required operating permit can be directly obtained from the Fairfax County Department of Environmental Health. It will require four sets of detailed plans specifying items such as square footage, number of occupants, method of operation, floor plan to scale, site plan to scale, etc. The Department will coordinate the process by forwarding a copy to each of the reviewing offices (e.g., sanitation, fire marshall). (If a zoning variance is obtained, then only sketches are required by this office.) An estimated two months, if no major problems occur, can be expected before the plans are
are returned--either approved or noting necessary changes
to be made. When the changes are completed, an on-site
inspection will be made and if passed, a temporary operating
permit will be granted at that time.

In Arlington, an application for a Certificate of
Occupancy is obtained when the request for a zoning variance
is made. The County Board will grant the Certificate after
the public hearings are held.

C. Space Considerations

In addition to meeting the standards set by the State for
licensure, several other space considerations must be considered
in selecting a proper facility. These include the following,
many of which were suggested by the Burke Rehabilitation Center.

1. Entrance and Exits

   The shorter the distance between the point of arrival
   and the entrance, the better. A covered walkway or ramp
   will allow for a reliable and safe walking surface during
   poor weather.

2. Safety Concerns

   Some potential hazards should be avoided. Glass
doors or large windows which can be confused with thorough-
fares should be avoided. Furniture with a protruding base
is undesirable. Low stools and footrests should not be
used. Sharp corners should be padded.

3. Bathroom(s)

   Those rooms should include toilet facilities usable by
the handicapped, have space large enough for changing soiled
clothes, have equipment to wash and clean incontinent parti-
cipants, possess locked cabinets for storage of first aid
supplies, clean washrags, and antiseptic soap. They should
be located in close proximity to activity areas.
4. **Access to Outside**

There could be an outside area which can be used all year. Everyone needs an area to walk and exercise, but a visual barrier is needed to prevent wandering. This would be a low fence or suitable shrubbery. The addition of outside chairs or benches would be useful.

5. **Quiet Room**

Occasionally, it will be necessary to move a participant away from the mainstream of activity. A small, quiet room for calming an agitated person which will prevent the spread of anxiety is important. It is useful for this area to have equipment to monitor vital signs. This room can also offer privacy for staff and participant or family conferences.

6. **Kitchen**

A kitchen is useful in reinforcing skills of daily living. It is especially important during holidays and birthdays. It should have a lockable refrigerator, a stove, sink, and a storage area (locked if drugs are kept there). It is not to be used for preparing lunches, but will be used for snacks.

7. **Furniture**

All furniture needs to be functional and movable. Recliners can be used by those who need rest periods built into their Individualized Program Plans. Large fabric chairs are to be avoided because they are easily soiled or wet. A collection of small tables, rather than one large table, will provide more versatility.

8. **Storage and Office Space**

A variety of items need to be locked. A large walk-in closet is best. Each staff person will need a desk and locker. Patient records must be kept in locked files to insure confidentiality.
9. **Warning Systems**

A bell or buzzer should be placed in toilets to summon help when needed.

10. **Fire Protection**

Fire extinguishers will be placed in the kitchen and activity areas and staff trained in their use. Fire drills will be conducted with both staff and participants. Smoke alarms also will be used.

D. **Square Footage Needs**

After consultation with several directors of similar programs, an estimate of 100 square feet of indoor space per program participant is considered optimum for conducting the proposed program. In addition, outdoor space to allow for supervised walking and other recreational activities will be provided. For the estimated 25 participants, a facility with 2,500 square feet would be suitable. In considering the needs discussed above, the following break-out is advisable:

- **Activity area** 1,500 square feet
- **Staff offices and storage area** 400 " "
- **Bathrooms** 200 " "
- **Kitchen** 150 " "
- **Quiet room/conference room** 150 " "
- **Transition room/entrance hall** 100 " "

**Total** 2,500 square feet

E. **Location Requirements**

Recognizing that the ADRDA service area covers all of Northern Virginia, a facility centrally located would be the fairest means of sharing the driving responsibilities of all participant families. A facility at either end of the area would clearly
place undue hardship on those living at the far end of the service area.

F. **Types of Facilities**

After examining the licensing standards, space considerations, square footage needs, and location requirements, we are prepared to investigate the options available for a day care center facility. Obviously our search must also consider a facility which does not require a major expenditure of funds to convert it to our program needs. Among the types of buildings to examine are the following:

- Vacant and available school buildings;
- Leasable church facilities with unused space during the day hours;
- Public buildings with vacant space during the day hours;
- Privately donated building space; and
- Private organization buildings with space unused during the day hours.
VI. LEGAL CONCERNS AND LEGAL PROTECTIONS

A. Sponsorship of the Center Program

Several suggestions have been made by ADRDA members regarding the auspices under which the Day Care Center should be operated. Some members have assumed it would become a program under the ADRDA Board Chapter Board; others have suggested a new non-profit corporation be created; and some have asked that we investigate the creation of a new organization—a cooperative owned by the members.

Proposed is the creation of a newly chartered non-profit membership corporation under the laws of Virginia, with the basic democratic control and ownership principles of a consumer-owned cooperative included in its articles of incorporation.

This assumes that families with participant members own the cooperative and, through membership meetings and an elected board, establish its basic policies.

Among the basic cooperative principles are the following:

1. One vote per member with no proxies;
2. Limited or no return on member investment;
3. Open membership—no restrictions due to race, religion, etc.;
4. Non-partisan in political activities; and
5. Net savings either retained in the business operation or distributed to members in proportion to the use of the services.

This new non-profit cooperative adult day care center will include on its board of directors those elected by and from the participating support families; and those named from the general public who have needed expertise; and those from the Alzheimer's Disease and Related Disorders Association of Northern Virginia. The exact number from each category will be determined.
A mechanism will be devised to allow contributors to the new cooperative to deduct their donations from their taxable income.

Appendix U contains a draft of the Articles of Incorporation and By-Laws from the new sponsoring organization.

B. Insurance Requirements

A variety of types of insurance will be purchased to minimize the risk of liability and loss. These are included below with dollar estimates based upon the information available today.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workman's Compensation --based on payroll</td>
<td>$200</td>
</tr>
<tr>
<td>General Liability --based on the facility used; contents coverage, plus $500,000 liability coverage</td>
<td>700</td>
</tr>
<tr>
<td>Professional Liability (Malpractice) --costs dependent on Director's education and training; all staff and volunteers are covered; $1 million coverage</td>
<td>500</td>
</tr>
<tr>
<td>Catastrophic Liability (Umbrella Policy) --$10 million coverage; covers after the $500,000 general liability limits are met</td>
<td>1500</td>
</tr>
<tr>
<td>Fidelity Bond --$10,000 bond</td>
<td>100</td>
</tr>
</tbody>
</table>

Total Costs $3000/yr. $250/mo.

C. Participating Family-Center Agreements

The following agreement will be utilized by the sponsoring agency for the Center and the Center's participating families:
AGREEMENT

AGREEMENT between (name of sponsoring agency), known as the "Sponsor" of "The Adult Respite Day Care Center" and (person designated as responsible family caregiver), for the "Participant," a family member with Alzheimer's disease or a related disorder.

1. SERVICES. By signing this Agreement, the designated responsible family caregiver is entitled to have a family member with Alzheimer's disease or a related disorder participate in the Center program.

2. TERM. Attendance in the Center program will continue as long as the monthly fees are paid. Family caregivers may terminate Participant involvement by writing to the Center at least ten calendar days before the termination is to be effective. However, if a Participant's circumstances change unexpectedly, or are beyond control, the Center may waive such notice.

The Center reserves the right to discontinue the provision of service through a written ten-calendar day notice if at any time it is determined the Center can no longer provide the support appropriate to the Participant's needs.

3. FEES. Responsible family caregiver shall pay an Initiation Fee of $50.00 when this Agreement is signed and before services are rendered. The Initiation Fee shall cover the cost of the initial interview and the preparation of the Participant's Individualized Program Plan. (The Individualized Program Plan is a detailed analysis of the Participant's needs and interests for specific support services, and a program for supporting the Participant's interest in functioning as independently as possible.) The Initiation Fee is non-refundable and may not be transferred or assigned to someone else.
In exchange for receiving the Center benefits, the responsible family caregiver shall also pay a monthly fee of $_______ for ___ days of Participant care per week.

Fees for Center services shall not be changed for at least six months, and thereafter may be changed no more than once every year.

The Center shall send an invoice for the monthly fee to the responsible family caregiver by the 15th of each month. The family caregiver shall pay the bill by the fifth day of the next month, or a late payment fee of 1.5% of the unpaid balance will be added to the next monthly bill. Center attendance may be terminated if fees are not paid for two consecutive months.

4. **MEDICAL INFORMATION AND AUTHORIZATION.** The responsible family caregiver shall be responsible for informing the Participant's personal physician of the activities in which the Participant will be involved while in attendance at the Center. The responsible family caregiver will take full responsibility for obtaining a written statement from the Participant's personal physician which describes any and all medical, physical, emotional, or dietary restrictions that may adversely affect full participation in Center activities. Such written notification shall be accomplished through the completion of the "Medical, Physical, Emotional, and Dietary Restrictions" form found as Exhibit I to this Agreement. Further, the responsible family caregiver shall be responsible for informing the Center in writing of any and all changes in his/her physical, medical, emotional, or dietary condition which may affect Participant involvement in Center activities. The responsible family caregiver shall attest to such agreement by affixing his/her signature to Exhibit I which shall hereby become a part of this Agreement.
The Center reserves the right to refuse Participant involvement in certain Center activities without prior written approval from the Participant's physician.

The responsible family caregiver authorizes the Center to seek emergency medical assistance on the Participant's behalf, if such a need becomes necessary.

5. **LIMITATION OF LIABILITY.** All staff used by the Center are experienced in working with elderly persons. All have been carefully screened. All have received pre-service training and are regularly supervised by a registered nurse. The Center will not be liable for any incidental or consequential damages arising from delay or non-performance of any service under this Agreement. The Center will not be liable for any damages due to circumstances beyond its control.

6. **ARBITRATION.** In the event of any dispute or claim under this Agreement, the matter shall be submitted to binding arbitration in accordance with the local rules of the American Arbitration Association. This provision shall not apply to claims for collection of unpaid monthly membership fees unless the responsible family caregiver has notified the Center in advance that they desire to arbitrate such a claim.
IN WITNESS WHEREOF, the parties have executed this Agreement this ______ day of ____________, 19____.

WITNESS:

______________________________

RESPONSIBLE FAMILY CAREGIVER: (for Participant)

(Signature)

______________________________

(Print Name)

______________________________

(Name of Participant)

______________________________

(Address)

______________________________

(Telephone)

______________________________

(Name of New Sponsoring Agency)

(Signature)

______________________________

(Print Name and Title)
EXHIBIT I

MEDICAL, PHYSICAL, EMOTIONAL, AND DIETARY RESTRICTIONS

The following medical, physical, emotional, or dietary restrictions may have an effect on the Participant's involvement in Center activities:

I agree to notify the Center of any and all changes in the Participant's medical, physical, emotional, and dietary conditions which may affect his/her involvement in Center activities.

(Signature of responsible family caregiver)

(Participant name)

(Date)
VII. BUDGET

A. Start Up Costs

A number of items will need to be obtained before the program can begin. The costs associated with these items are one-time costs and, therefore, are not calculated within the Center Operating Budget. Included in the anticipated start-up costs are the following:

- Legal incorporation fees $ 500
- Printing 1,250
  --stationery ($250)
  --brochures ($1000)
- Furniture and other furnishings 5,000
- Rental and phone deposits 750
- Renovations 2,500

Total Start-up Expenses Anticipated $10,000

Income from non-participant sources (unless a one-time sign-up fee is created) will be used to cover these one-time costs. Some items, like furnishings, may be obtained through donation, thus reducing the start-up cost requirement.

B. Initial Monthly Deficits

In addition to these one-time start-up costs, adjustments must be made to account for the reduced daily attendance (and, therefore, income) during the initial months of the Center's operation.

In anticipation of the lower daily attendance, some operating expenses will not be encumbered upon the opening of the Center. The following operating budget adjustments will be made during the initial months.

- The full complement of staff will not be hired until the full complement of daily participants is achieved.
Staff will be added in accordance with the 1-5 ratio of staff-participants. This also will allow for less costs incurred in payroll taxes and fringe benefits; and

- Costs for consumable items used by participants, such as meals and activity materials, also will be reduced.

Monthly deficits from the time the Center opens until daily attendance reaches an average of 20 are expected for the first four months of operation. These are displayed on the "Monthly Cash Flow Projections" chart that follows. In sum:

- Month 1  - $2,553
- Month 2  - 1,323
- Month 3  - 647
- Month 4  - 316

-$4,839 Total Deficit Expected

C. Costs of Director Prior to Center Opening

The hiring of the Center Director on a quarter time basis to provide the leadership in the developmental activities required for the program's initiation, as well as to work with the new Board in its development and training is also anticipated. The costs involved are displayed as follows:

- Salary $500/month x 4 months $2,000
- Fringes $100/month x 4 months 400
- Payroll Tax $66/month x 4 months 264

Total Costs $2,664

D. Summary of Funding Needs

When the anticipated Monthly Deficits ($4,839) are added to the anticipated one-time Start-Up Costs required ($10,000), and the costs of the Director prior to the Center's opening ($2,664) are added, a total cost of $17,503 will be required until the program becomes self-supporting.

Obviously, donations (e.g., free rent for the facility or furniture) would reduce costs considerably.
## Monthly Cash Flow Projections - Start Up

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<th>(6)</th>
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<td><strong>I. Average Daily Partic. Anticipated</strong></td>
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<td>6</td>
<td>17</td>
<td>15</td>
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<table>
<thead>
<tr>
<th><strong>II. Expenses Anticipated</strong></th>
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<td><strong>Direct Labor</strong></td>
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<tr>
<td>Director</td>
<td>$1000</td>
<td>$1000</td>
<td>$1000</td>
<td>$2000</td>
<td>$2000</td>
<td>$2000</td>
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<tr>
<td>Assistant Dir.</td>
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<td>-</td>
<td>333</td>
<td>667</td>
<td>667</td>
<td>1333</td>
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<tr>
<td>Prog. Assist. (2)</td>
<td>500</td>
<td>500</td>
<td>1000</td>
<td>1000</td>
<td>1500</td>
<td>2000</td>
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<tr>
<td>General Assist.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>Office Assist.</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td>500</td>
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<tr>
<td>Fringe @10% DL</td>
<td>200</td>
<td>200</td>
<td>283</td>
<td>417</td>
<td>467</td>
<td>650</td>
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<tr>
<td>Payroll Taxes @6% of DL</td>
<td>132</td>
<td>132</td>
<td>165</td>
<td>281</td>
<td>314</td>
<td>429</td>
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<td><strong>TOTAL DL</strong></td>
<td>$2332</td>
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<td>$3281</td>
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<td>$5448</td>
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<thead>
<tr>
<th><strong>Other Direct Costs</strong></th>
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<tbody>
<tr>
<td>Telephone</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>75</td>
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<td>100</td>
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<td>Office Supplies</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>20</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Meal Prep. Service @$2/meal</td>
<td>200</td>
<td>280</td>
<td>400</td>
<td>600</td>
<td>800</td>
<td>1000</td>
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<tr>
<td>Insurance</td>
<td>250</td>
<td>250</td>
<td>250</td>
<td>250</td>
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<tr>
<td>Accounting</td>
<td>42</td>
<td>42</td>
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<td>42</td>
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<tr>
<td>Attorney</td>
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<td>Rent</td>
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<td>625</td>
<td>625</td>
<td>625</td>
<td>625</td>
<td>625</td>
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<tr>
<td>Utilities and Main.</td>
<td>156</td>
<td>156</td>
<td>156</td>
<td>156</td>
<td>156</td>
<td>156</td>
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<tr>
<td>Activity and Part. Consumable Mater.</td>
<td>25</td>
<td>35</td>
<td>50</td>
<td>75</td>
<td>100</td>
<td>125</td>
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<tr>
<td>Printing and Postage</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>75</td>
<td>75</td>
<td>100</td>
</tr>
<tr>
<td>Publicity</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
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<td><strong>TOTAL ODC</strong></td>
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<td>$1631</td>
<td>$1766</td>
<td>$2051</td>
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<td>$2556</td>
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<table>
<thead>
<tr>
<th><strong>TOTAL EXPENSES ANTICIPATED</strong></th>
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<tr>
<td>$3873</td>
<td>$3963</td>
<td>$5047</td>
<td>$6916</td>
<td>$7724</td>
<td>$9951</td>
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</table>

| **III. Income Anticipated from Participants** | $1320 | $2640 | $4400 | $6600 | $8800 | $11000 |

| **IV. TOTAL DEFICIT ANTICIPATED** | $-2553 | $-1323 | $-647 | $-316 | $+1076 | $+1049 |
E. Costs of Operating the Program - Operating Budget

The following costs will be incurred in the operation of the program for an average daily attendance of 25 participants.

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Labor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director</td>
<td>$2,000</td>
<td>$24,000</td>
</tr>
<tr>
<td>Assistant Director</td>
<td>1,333</td>
<td>16,000</td>
</tr>
<tr>
<td>Program Assistants (2 @ $12,000/year)</td>
<td>2,000</td>
<td>24,000</td>
</tr>
<tr>
<td>General Assistant (1/2 time @ $12,000/year)</td>
<td>500</td>
<td>6,000</td>
</tr>
<tr>
<td>Office Assistant (1/2 time @ $12,000/year)</td>
<td>500</td>
<td>6,000</td>
</tr>
<tr>
<td>Fringe @ 10%</td>
<td>633</td>
<td>7,600</td>
</tr>
<tr>
<td>Payroll Taxes (Social Security, Unemployment, income @ 6% of DL)</td>
<td>429</td>
<td>5,148</td>
</tr>
<tr>
<td>TOTAL DIRECT LABOR</td>
<td>$7,395</td>
<td>$88,748</td>
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Other Direct Costs

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>100</td>
<td>1,200</td>
</tr>
<tr>
<td>Office Supplies (consumable)</td>
<td>25</td>
<td>300</td>
</tr>
<tr>
<td>Meal Preparation Service ($2 per meal)</td>
<td>1,000</td>
<td>12,000</td>
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<tr>
<td>Insurance</td>
<td>250</td>
<td>3,000</td>
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<tr>
<td>Accounting</td>
<td>42</td>
<td>500</td>
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<tr>
<td>Attorney</td>
<td>83</td>
<td>1,000</td>
</tr>
<tr>
<td>Rent, Utilities &amp; Maintenance</td>
<td>781</td>
<td>9,375</td>
</tr>
<tr>
<td>Activity and Participant Consumable Materials ($0.25/part./day)</td>
<td>125</td>
<td>1,500</td>
</tr>
<tr>
<td>Printing and Postage</td>
<td>100</td>
<td>1,200</td>
</tr>
<tr>
<td>Publicity</td>
<td>50</td>
<td>600</td>
</tr>
<tr>
<td>TOTAL OTHER DIRECT COSTS</td>
<td>$2,556</td>
<td>$30,675</td>
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</table>

TOTAL EXPENSES

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL EXPENSES</td>
<td>$9,951</td>
<td>$119,423</td>
</tr>
</tbody>
</table>
F. Income

If we assume an average daily attendance of 25 participants \times 20\text{ days of service per month}, we can calculate 500 participant days/month of service. When we divide the $9,951 monthly operating costs into the 500 participant days of service, we note a daily cost of $19.90 for each participant day of service. A charge of $22 per participant day of service, allowing for some unexpected expenses and the potential use of sponsorship for those who may not be able to afford the costs, appears to be appropriate. In addition, if two weeks a year are to be used for staff training and planning while the Center is closed, then a loss of revenue ($22/day \times 25\text{ participants} \times 10\text{ days} = $5,500) must be expected. This charge is similar to that of most other similar programs operating elsewhere in the country, as well as those other adult day care programs operating in Northern Virginia.

G. Sources of Income

The source(s) from which the program operating costs are gathered present options for consideration. For example:

- Charge participants full fee for the costs of service (i.e., $22/service day); or

- Charge participants less than full fee and supplement the deficit from other sources, or from surplus program revenues.

Among the other potential sources of revenue to be considered are the following:

- Service, religious, or business organizations which may be interested in supporting this cause (e.g., Knights of Columbus, Chamber of Commerce, church groups);

- Individual or corporate tax-deductible donations solicited through a program of deferred giving or memorials;
The creation of a "sponsorship" program sold through a fundraising campaign to interested individuals and corporations (e.g., $5,280 will allow someone to become a full sponsor which will allow one participant to attend the Center full time for one year);

Government research and/or demonstration program funds may be available for this unique program designed to meet the needs of a growing national problem (e.g., The National Institute of Mental Health, Aging Division, currently is interested in supporting projects on Alzheimer's disease); and

Foundations concerned with the elderly may find this unique program of interest to them (e.g., MacArthur Foundation, Johnson Foundation, and locally the Stern Family Fund).

Some sources may be attracted to the subsidizing of particular budget items such as providing the facility at no or minimum cost, contributing activity materials, furniture, or free printing costs.

For each dollar obtained through an outside source, the operating costs shared by participants can be lowered by that amount.
VIII. IMPLEMENTATION SCHEDULE

The following milestone chart provides a listing of those activities and dates required to open the Adult Respite Day Care Center by May 1, 1984.

In order for this goal to be accomplished, the time and effort of many ADRDA Northern Virginia Chapter members will be required under the leadership of the Chapter President and Executive Committee.

The tasks to be accomplished have been clustered into three significant areas:

- New Board development/director recruitment;
- Obtaining a facility; and
- Fundraising.

It should be noted that in case a facility can be obtained which does not require the lengthy zoning variance process, and the required start-up costs can quickly be obtained, a significantly earlier facility opening could be expected.
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<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>NOV 83</th>
<th>DEC 83</th>
<th>JAN 84</th>
<th>FEB 84</th>
<th>MAR 84</th>
<th>APR 84</th>
<th>MAY 84</th>
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<tbody>
<tr>
<td>II. Fundraising</td>
<td></td>
<td></td>
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<tr>
<td>Review start-up funding needs</td>
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<tr>
<td>Develop fundraising strategy</td>
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<tr>
<td>Develop list of sources of fund.</td>
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<tr>
<td>Send proposals to governmental and foundation sources</td>
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<tr>
<td>Make presentations to service, religious, business org.</td>
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<tr>
<td>Publicize donations, sponsorship</td>
<td>▲</td>
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<tr>
<td>Recruit participants</td>
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<tr>
<td>DESCRIPTION</td>
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<tr>
<td>I. New Board Devel./Dir. Recruit.</td>
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<td>Review Articles of Incorp., By-laws &amp; potential Board members</td>
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<td>Meet with Attorney to finalize Articles of Incorp. &amp; Bylaws</td>
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<td>File for incorporation</td>
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<td>Invite members to join Board</td>
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<td>Develop job descrip. for Director</td>
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<tr>
<td>Advertise for Director</td>
<td></td>
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<tr>
<td>Screen candidates for Director</td>
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<tr>
<td>Hire Director - ½-time</td>
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<td>Develop agenda &amp; schedule</td>
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<tr>
<td>Conduct Board training sessions</td>
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<tr>
<td>II. Obtaining Facility</td>
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<tr>
<td>Review facility requirements</td>
<td></td>
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<tr>
<td>Visit potential facilities &amp; determine modifications req'd.</td>
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<td>Select 1st choice facility</td>
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<td>Develop sketch of facility with modifications required</td>
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<tr>
<td>Meet w/County Environ. Hlth. Dept.</td>
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<td>Obtain liquor license inspection</td>
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21. Sands, Dan, Ph.D. "Opening a Day Care Center for Persons with Alzheimer's Disease and Related Disorders - Harbor Area Adult Day Care Center." Costa Mesa, CA, 1983.


26. Ibid., p. 5.

APPENDICES
APPENDIX A

ADRDA/No. Va. Membership Questionnaire

**QUESTIONNAIRE**

Please answer the following questions and send your responses to the Chapter P.O. Box or bring them with you to the August 11th meeting.

Name __________________________ Phone # __________

Assuming we offer a 5 day a week, 7:30am to 6pm daycare facility:

1. How many days a week would you use it?
   ________________________________

2. Which hours during the day would best suit your needs? morning __________
   afternoon __ full day __ other __________

3. How much would you be willing to pay per hour for such a program?
   ________________________________

4. Will you need transportation? yes __ no __

5. Would you volunteer at the center as a means of reducing costs? yes __ no __

6. How many hours a week are you prepared to volunteer?
   ________________________________

7. Would you like to work with us to plan the program? yes __ no __
APPENDIX B

Physician Approval for Participation

Physician's Report

Patient of, or applicants for admission to, Community Care Facilities

Date:

HARBOR AREA ADULT DAY CARE CENTER
661 West Hamilton
Costa Mesa, CA 92627
(714) 548-9331

NOTE TO PHYSICIAN:
The person whose name appears below is a resident of, or an applicant for admission to, a licensed community care facility. These facilities provide the personal care and supervision normally provided by a relative or a member of the family. A current health report is required on each person in the facility.

COMMUNITY CARE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.

NAME

AGE

4. SEX

5. DATE OF EXAMINATION

6. LENGTH OF TIME UNDER YOUR CARE

7. SOCIAL SECURITY NUMBER

DIAGNOSIS

TUBERCULOSIS EXAMINATION

HOW DETERMINED

DATE

☐ ACTIVE OR QUIESCENT

☐ INACTIVE OR NONE

OTHER CONTAGIOUS OR INFECTIOUS DISEASES

☐ HOME IF ANY, SPECIFY

HEALTH

GENERAL HEALTH

☐ GOOD

☐ FAIR

☐ POOR

AUDITORY IMPAIRMENT

☐ HOME

☐ MILD

☐ SEVERE

VISUAL IMPAIRMENT

☐ HOME

☐ MILD

☐ SEVERE

SPECIAL DIET (SPECIFY)

☐ None

☐ Occasional

☐ Frequent

ALCOHOLIC PROBLEM

☐ None

☐ Occasional

☐ Frequent

DRUGS:

YES | NO

(CHECK ONE)

CAPACITY FOR SELF-CARE

YES | NO

(CHECK ONE)

Is able to care for all personal needs

☐ Yes

☐ No

Can administer own medication

☐ Yes

☐ No

Needs help with medication

☐ Yes

☐ No

Instructions prescribed and instructions given

Patient (specify)

☐ Yes

☐ No

Care for toilet needs

☐ Yes

☐ No
REQUIRES ASSISTANCE FOR:

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PROFESSIONAL NURSING CARE NEEDS

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Requires continuing bed care
Requires the administration of medicines not safe for self-administration

(Requires frequency and amount of medicine determined on the basis of daily professional observation of symptoms or laboratory tests)

EN SPECIAL TREATMENTS OR NURSING PROCEDURES (SPECIFY - E.G. - OXYGEN - INDOVENGL CATHETER, ETC.)

IMPORTANT:

Your opinion is the person mentally and physically capable of leaving the building without assistance in an emergency?

Yes □ No □ If No, explain:

PHYSICIAN'S NAME [TYPE OR PRINT] ADDRESS TELEPHONE

NATURE OF PHYSICIAN DATE

(Use this section if additional space is needed.)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of medical information contained in the report of the examination of

HARBOR AREA ADULT DAY CARE CENTER

681 WEST HAMILTON
Costa Mesa, CA 92627

[NAME AND ADDRESS OF AGENCY, INSTITUTION, OR REQUESTING INFORMATION] (714) 569-9331

medical information is required to assist the above-named agency in determining the type of care needed.

SIGNATURE DATE ADDRESS

23701-60 9-82 97M - GSP
1. Name of CLIENT: ____________________________________________
   ADDRESS
   ____________________________________________
   ____________________________________________

2. Name of Family Member or Contact: ______________________________
   Address
   ____________________________________________

INFORMATION:

Age: _______________ Present Living Situation _________________________

Why Interested in Day Care? _________________________________________

Date of Interview: _______________ Date of Admission to Program ________

Release sent to Physician ________________________ Applied for Financial
   Assistance ________

Approved for Financial Assistance __________________

Other Comments or Information:
APPENDIX D
Client Record Data Base
HARBOR AREA ADULT DAY CARE CENTER
DATA BASE
Client Record

1. Name __________________________
   Address __________________________________________
   Telephone ______________________________

2. Emergency Contact (Name) __________________________
   Address __________________________________________
   Telephone ______________________________ Relationship ____________
   Place of Employment __________________________________
   Telephone (Work) __________________________

3. Physician's Name __________________________
   Address __________________________________________ Phone ______________________

4. Medical Section
   A. History of surgeries, diseases, health problems

B. Current Health status
   1. Diagnosis
   2. Medications and Dosage
   3. Activity Restrictions
   4. Health aids (glasses, hearing aid, dentures, braces, pacemakers, etc.)
   5. Diet

C. Psychiatric History: Affective/Behavioral
   Suicide attempts; significant aggressive behaviors; depression.
   Ask extent of involvement, hallucinations, delusional, feels persecuted, etc.
5. Current Social Assessment

A. Living Status
   Does client live alone?
   Describe degree of independence
   (a) mobility
   (b) cooking
   (c) laundry

B. Describe family support network and losses.

C. Describe peer relationships, community participation (church, social, recreational)

D. Source of referral to Day Care Program and alternatives explored.

E. Applicant's motivation for participation

6. Other information: Client's special interests and talents

7. Problems from Outreach Worker's View:

(unsigned: Interviewer)
EMERGENCY PROCEDURE

In case of any change in behavior or physical condition perceived by the staff to require immediate medical attention, our policy is to:

1. Call the paramedics
2. Call the client's physician
3. Call the family

If hospitalization is necessary, paramedics will bring the client to Costa Mesa Memorial Hospital, unless directed otherwise.

I understand and agree with the above procedure.

________________________________________
Name

________________________________________
Date
APPENDIX F

Patient Interest Profile
Occupation: ____________________ Birthday: ________________ Age: ________________
Years of School: ________________ Religion: ____________________
Visitors: __________________________ Special Diet: ________________
Diagnosis: __________________________

PERSONAL ORIENTATION
☐ Distinguishes between past and present events
☐ Is over concerned with self
☐ Is content concerning self
☐ Is content in environment
☐ Is aware of surroundings and needs
☐ Responds to meaningful moments
☐ Has a religious orientation
☐ Is generally happy
☐ Accepts personal limitations
☐ Desires to be useful
☐ Is concerned for personal dignity
☐ Seeks personal satisfaction in achievement
☐ Desires recognition of individuality
☐ Generally thinks constructively
☐ Has confidence in others
☐ Has natural curiosity
☐ Holds positive attitudes

RELATIONSHIPS
☐ Prefers to be alone
☐ Participates well in group experiences
☐ Wants to help others
☐ Seeks out companionship
☐ Reacts well to competition
☐ Is able to accept others
☐ Reacts in hostile manner to others

INTERESTS AND HOBBIES
- Music   - Creative Writing
- Weaving  - Fishing
- Knitting  - Card Games
- Crocheting  - Sports
- Sewing   - Cooking
- Word Games  - Other
- Gardening   - Table Games
- Photography  - Checkers
- Painting  - Chess
- Ceramics   - Yahtzee
- Puzzles

COMMENTS: ______________________________________________

GOALS OF ACTIVITY PLAN
- Remotivation
- Socialization
- Prevent preoccupation
- Learn new skills
- Increase attention span
- Restore feeling of self worth
- Reduce incontinency
- Promote a healthy lifestyle
- Reduce overt self pity
- Mood elevator
- Reduce confusion
- Promote good personal habits
- Reduce psychological regression
- Acceptance of personal limitations
- Satisfaction and contentment

TYPES OF NEEDED ACTIVITIES
- Physical exercise
- Entertainment
- Competition
- Communication
- Meaningful work
- Educational stimulation
- Creative expression
- Community involvement
- Self care
- Social interaction
- Service to others
- Sensory stimulation
- Health maintenance
- Release of tension
- Leadership involvement
- Emotional expression
- Spiritual encounter

SELF CARE ACTIVITIES: IF PATIENT IS TO BE INVOLVED IN SELF CARE AND WORK RELATED ACTIVITIES, CHECK THOSE THAT ARE TO BE USED:

Make own bed   - Deliver Mail
Clean Room  - Gardening
Dress self  - Straighten library
Shower self  - Other
Fold linen

PHYSICIAN: PLEASE READ AND SIGN
I have read and approve the activity treatment plan for Mr./Ms. ________________________
Signed ________________________
Date ________________________

The activity plan can be followed except for the following restrictions: ______________________________________________
______________________________

This patient can:  PLEASE CIRCLE!
Yes   No  Leave the facility to go on field trips
Yes   No  Have (on occasion) an alcoholic beverage
Yes   No  Participate in self care and work related activities.

PATIENT INTEREST PROFILE
SIGNED ________________________ DATED ________________________
ARTISTIC PRESS 1974
FORM 3325
APPENDIX G

Activities of Daily Living

Name ____________________

(Mark one only)

TOILET

1. Cares for self at toilet completely, no incontinence

2. Needs to be reminded or needs help in cleaning self, or has rare (weekly at most) accidents

3. Soiling or wetting while asleep more than once a week

4. Soiling or wetting while awake more than once a week

5. No control of bowels or bladder.

FEEDING

1. Eats without assistance

2. Eats with minor assistance and is untidy, needing help cleaning up

3. Eats with minor assistance for all meals

4. Requires extensive assistance for all meals

5. Does not feed self at all and is uncooperative with others feeding him/her

DRESSING

1. Dresses, undresses and selects own clothing—needs no assistance

2. Needs minor assistance sometimes, but for the most part can dress and undress

3. Needs some moderate assistance always in dressing and undressing

4. Needs major assistance, but cooperates with efforts of others to help

5. Needs major assistance, and resists efforts of others to help

GROOMING (neatness, hair, face, hands, nails, etc.)

1. Always acceptably groomed without assistance

2. Needs minor assistance in grooming, and occasional reminders.

3. Needs regular supervision or assistance in grooming

4. Needs total grooming care, but remains interested in staying well-groomed

5. Needs total grooming care, but is not interested in maintaining grooming; sometimes resists and negates efforts of others
E. BATHING

___ 1. Washes self without help

___ 2. Washes self with help getting in and out of tub or shower

___ 3. Washes self with little assistance, but needs to be reminded to bathe.

___ 4. Needs to be bathed by others, but cooperates

___ 5. Needs to be bathed by others, but resists and refuses to cooperate

F. AMBULATION

___ 1. Walks unassisted usually

___ 2. Walks with only arm or rail or chair for support, usually; or walks with a walker

___ 3. Walks if given substantial support

___ 4. Moves self around in wheelchair, can get in and out alone

___ 5. Moves self around in wheelchair, must be lifted in and out

___ 6. Must be pushed around in wheelchair

G. ACTIVITY

___ 1. Gets out of bed and dressed in morning, remains out until bedtime with one nap, at most, during day

___ 2. Gets out of bed in morning, but naps off and on through day

___ 3. Gets out of bed if reminded

___ 4. Gets out of bed if reminded and assisted

___ 5. Gets up only when forced; when spends most of day out of bed

___ 6. Spends whole day in bed, could be out more often

___ 7. Spends whole day in bed, too sick to get out.

H. EYESIGHT

___ 1. Normal or better

___ 2. Slightly impaired; can read, but for limited time periods

___ 3. Somewhat impaired; can read large print, see movies, etc.

___ 4. Considerably impaired; unable to see well enough to read, but can distinguish faces, etc.

___ 5. Functionally blind
I. HEARING

1. Normal or better

2. Slightly impaired; occasionally asks "what", etc.

3. Somewhat impaired; hears about half of what is said to him, does not hear others' conversations well

4. Considerably impaired; has great difficulty hearing.

5. Functionally deaf.

J. SPEECH (Quality of speech, not content or meaning)

1. Normal or better

2. Slightly impaired; may give brief response to repeated question

3. Slightly impaired; at times garbled

4. Somewhat impaired; one must concentrate; hard to understand

5. Considerably impaired; one can only pick out occasional words; or person speaks in fragments, only expressing needs, etc.

6. Mute; or impossible to understand
1. Neck Circles: make slow circles letting your neck really stretch.

2. Shoulder Rotations: make circle using both shoulders.

3. Arm Lifts: hold your involved arm across your body and lift up and out.

4. Arm Chops: hold your involved arm at your side and lift up and across your face.

5. Pronation/Supination: place hands on your lap, palms up. Now turn them down. If not possible use the good hand to help out the involved one.

6. Finger ROM: open your fingers as wide as possible and then close tightly. You can help out with the other hand.

7. Trunk Rotation: with arms crossed in front of you, touch your right elbow to your left knee. Straighten and then touch the left elbow to the right knee.

8. Rock the Baby: cross your arms in front of you and rock them back and forth as if rocking a baby.

9. Elbow Lifts: with arms crossed, lift both elbows way up and over your head.

10. Marching in Place: while sitting lift first one knee, then the other as high as possible so you're marching in place.

11. Toe Touches: sitting, bend at the waist and touch your toes. Straighten and repeat.

12. Upper Extremity Reciprocation: lift first the right arm over the head as far as possible then the left. Alternate back and forth.

13. Upper Extremity and Lower Extremity Reciprocation: lift left knee and right arm up. Then repeat with the right knee and left arm. Alternate back and forth.
14 Daphragmatic Breathing: place one hand on your stomach right below your ribs. As you breathe in, your stomach should rise, as you blow out, it should fall.

15. Chair Scoots: start by sitting at the very back of your chair. Scoot forward to the front by "walking" your hips forward. Don't lean backwards. Then walk them backwards till you're sitting in your normal position.

16 Ankle Dorsiflexion: sitting with feet flat on the floor, raise your toes up. Hold and then relax.
RANGE OF JOINT MOTION EXERCISES

Definition: ROJM is the extent of movement within a given joint.

General Principles:

1. These exercises retain and rebuild muscle strength. They also prevent stiffness of the joints caused by muscle contractions.

2. Remember to use good body mechanics. Keep the patient relaxed and well-aligned, with her limbs close to her body.

3. Work slowly and smoothly and observing the patient's facial expression for signs of discomfort. Do not exercise the patient past the point of pain.

4. You must have a thorough knowledge of your patient's illness and limitations.

5. Constantly encourage your patient to take a more active part in her exercise program, as independence is one of the major goals of rehabilitation.

Passive Exercise - when the nurse performs an exercise for the patient.

Active Exercise - exercises performed without the help of the nurse or therapist.

Hyperextension of the Cervical Spine or Neck - bending the neck backward.

Flexion of the Cervical Spine or Neck - bending the neck forward.

Lateral Flexion of the Neck - bending sideways.

Rotation of the Neck - turning the head in a circular motion.

External Rotation of the Shoulder - rotating the arm backward (affects shoulder joint.)

Internal Rotation of the Shoulder - rotating the forearm forward.

Flexion of the Shoulder Joint - the arm swings forward and upward.

Extension of the Shoulder Joint - the arm returns to the side of the body.

Hyperextension of the Arm - as it swings backward.

Abduction of the Shoulder Joint - move the arm away from the side of the body.

Adduction of the Shoulder Joint - return the arm to the side.

Flexion of the Elbow - bending of the elbow.

Extension of the Elbow - straightening of the elbow.

Supinate the Hand - rotate the palm upward.
Prorate the Hand - rotate the palm downward.

Ulnar and Radial Deviation - the wrist can deviate toward the little finger side and the thumb side of the hand.

Opposition of the Thumb - placing of the palmer surface of the thumb so that it faces the fingers. Move the thumb in a larger circle toward each finger and return it to its original position.

Flexion of the Fingers - curl the fingers downward until they form a fist.

Extension of the Fingers - straighten the fingers.

Abduction of the Fingers - spreading the fingers apart.

Adduction of the Fingers - bringing the fingers together.

Flexion of the Knee - bending the knee.

Extension of the Knee - extending the knee.

Abduct the Hip Joint - support the patient's leg at the knee and ankle and bring it to the side.

Adduct the Hip Joint - reverse the above.

External Rotation of the Hip - roll the hip outward.

Internal Rotation of the Hip - roll the thigh inward.

Dorsiflexion of the Foot - pointing the foot upward.

Plantar Flexion of the Foot - pointing the foot downward.
Planning An Activity

PURPOSE: What are you trying to accomplish? At the group level? Individual level? Some goals to consider: awareness of self, others, environment; stimulation (physical/mental); interaction; development of skills; carry over into daily life; meeting individual needs; controls, sense of accomplishment, specific motor requirements, etc.

MATERIALS: What materials are needed? What is on hand? Are purchases necessary? Get prior authorization. Can materials be gathered by the members themselves?

I. SKILLS: What adjustments have to be made to fit individual and group needs? (Grading of the activity).
1. Amount of physical exertion required.
2. Degree of emotional threat.
3. Sight requirements
4. Hearing requirements
5. Mental Agility, e.g., concentration, orientation, psycho-motor functions.
6. Mental ability, e.g., reading level.
7. Dexterity/mobility/range of motion/gross and fine motor skills.
8. Motivation/interest (relate to and use life experience of group)
9. Type of materials used: can they be manipulated easily (large enough); note textures, colors, contrasting work surface.
Who in the group already has the required skills? How can these be used to help other members? Who might need individual attention and how can this be accomplished?

STEP BY STEP PREPARATION: Have opportunities been provided for prior discussion and client input? How much of the preparation and planning should be done ahead, how much left to the members themselves? (relate this back to Goals). Introduce the activity using multiple sensory clues (visual, aural, tactile). Present one idea at a time. Consider reality of what can be accomplished in a given work period (relate this back to skills). What are the steps involved? (Break them down). Consider producing a sample of finished product that group can relate to (alternately or concomitantly model along with clients).

TIME: How much time is required? Is this planned for one time period or to extend over many days? Is morning or afternoon most appropriate? Be sure to finish activity!

Staff: Plan staff ratio required, including students, and volunteers.

2. Ventilation
3. Handling of sharp equipment
4. Physical limits set for client
5. Amount of supervision required
6. Seating according to physical needs and limitations, e.g., back to light, hard chair, chair with arms.

FOLLOW-UP: 1. Responsibility for cleaning up
2. Storage of unfinished product.
3. Reinforcement of client’s effort and accomplishment.
EXIBILITY: What are the conditions on any given day which might require changes in planning, including cancelling the activity altogether?
1. Give priority to immediate confrontation of individual crisis or group conflict
2. General physical/emotional level of the group
3. The weather/transportation

EVALUATION: Purpose and procedure review
1. How did staff function? What adaptations were made?
2. How did client function in task: realistic choices, response to direction, follow through, body function; work habits
3. What is therapeutic value of the activity? To the individual, to the group.
GUIDELINES FOR TEACHING OLDER ADULTS

The translation of research findings into suggestions for teaching in the clinical situation is undertaken with a degree of humility. In the first place, research in the area of learning by older people is limited. The great majority of research efforts have been, and still are focused on the learning and teaching of the young. In the second place, the subjects involved in most of the studies are considered "normal", that is, without evidence of the pathological changes experienced by patients in health care settings. Third, direct application of most research findings to practice is rarely possible and may not even be desirable without considering the characteristics of the population being served and the available resources of staff and setting. The cautionary words of Kent seem appropriate "...the world of action cannot always wait upon the world of research, but it is inexcusable to give the impression that we are operating not on the basis of our best guesses given limited evidence but that we are operating on the basis of scientific evidence." Therefore, the guidelines are offered in the spirit of just that -- guides. They are not purported to be a set of principles, dictums or a concretized sequence of steps. Such presence would be a disservice to the professional reader and most certainly to the older person he seeks to teach.

Guidelines

The following guidelines take into consideration selected sets of conditions identified by research that influence the learning of aged adults:

1. Select visual aids that minimize the need for visual acuity or precise discrimination.

2. Seek a position in physical relationship to the person so as to maximize the strength and clarity of sensory stimuli.

3. Adjust word/min. rate to a level that makes the auditory inputs clearly perceptible to the person.

4. Determine with the older person the type of aid or media for input that facilitates his learning: e.g., auditory, visual, tactile or some combination.

5. Utilise teaching strategies or materials that permit the person to control the presentation pace of content to be learned.

6. Seek Feedback from the person regarding such things as pace, speech intelligibility, meaningfulness of content.

7. Select a place and time when simultaneous activity in the environment will be minimal in order that competing stimuli will not disrupt the person's learning.

8. Select a time for teaching when the person is not preoccupied with other concerns, e.g., recovery from illness, grieving, or finances.
9. Provide opportunities for recall of new information and practice of performance of tasks preferably within a day's time, or within a week of presentation at most.

10. Relate new learning to the past and present experiences of the person.

11. Integrate new behaviors with established and ongoing behaviors and activities so as to enhance memory.

12. Establish goals for learning that are mutually agreed upon by the older adult and the practitioner.

13. Establish short-term goals that are achievable and related to long-term goals in a meaningful way.

14. Determine what constitutes positive reinforcement for a given individual.

15. Provide opportunities for successful learning, prompt feedback and ample reinforcement for the level of performance achieved by the individual.

16. Encourage the person to participate in decisions related to when, how and what learning is to occur.

17. Encourage the expression and utilization of information brought by the older person to the teaching-learning situation which concerns the individual and situational variables operating in his life and which may relate to his learning.

18. Utilize terminology and examples familiar to the individual.

19. Consider the person's comfort and level of available energy.

20. Capitalize on the older person's (and one's own) reservoir of common sense and sense of humor.

These guides are not mutually exclusive and certainly not all inclusive.
Arts & Crafts

Manipulative Skill Development For The Older Adult

Purpose:

A basic manipulative skills class for the older adult which concentrates on improvement of motor skills and decision making through utilization of a variety of art media and techniques. Projects are designed to produce items for personal use, gift giving and selling, emphasizing and utilizing recycled materials.

Objectives:

1. To utilize various materials in a creative and expressive manner.

2. To visually and manually follow instructions in creating objects.

3. To be exposed to many different materials and in the process, originate creative objects.

4. To interact with other participants in a supportive and creative manner.

5. To derive a sense of self-worth and accomplishment through the completion of projects.
CRAFT INSTRUCTIONS

1. BE PATIENT
2. HAVE MODEL MADE.
3. KEEP EVERYTHING SIMPLE
4. KEEP CRAFTS FUNCTIONAL AND/OR CREATIVE.
5. USE LIGHT AND BRIGHT COLORS
6. GIVE SIMPLE INSTRUCTIONS, ONE AT A TIME.
7. BE FLEXIBLE; BE WILLING TO CHANGE INSTRUCTIONS.
8. BE WILLING TO TAKE RESPONSIBILITY IF PROJECT COMES OUT BADLY
9. ACCEPT THEIR SUGGESTIONS
10. KEEP TECHNIQUES FAMILIAR
11. BE ENTHUSIASTIC
Facilitating Techniques

1. Active Listening - Feedback (see other sheet)
   a) **reflective** - clarifying feeling and reason for feeling.
   b) **summarizing** - verbalizing what you see person doing or saying to help them see what they are doing more objectively.
   c) **confrontation** - helping people see where behavior and expressed needs or desires do not match so they can take steps to change one or the other.

General Guidelines

1. Do not be too persistent.
2. Do not argue - listen to feelings.
3. Observe non-verbal cues - do not just let them pass.
4. If counselling situation threatens person - begin with general questions then work to more specific.
5. Never ask why.
6. Allow people to be themselves - preserve their dignity.
7. Help them increase their self-determination.
8. Don't force your help on anyone - no one will benefit from counselling unless they are engaged in it.
9. Make sure the person you are talking with understands what you are trying to say - if not - repeat it.
10. Make your communications short - do not put 2 ideas into one sentence. i.e. - if you said, "Isn't it a nice day, the grass is blue." The person has to respond to 2 ideas - yes or no the grass is blue.
11. Ask open ended questions - not ones which make a judgement in the question such as - Isn't it a nice day?
12. Keep all commitments you make! Make only those you intend to keep.
13. Encourage people to see themselves as a cause of their circumstances rather than the effect (encourage to take responsibility for themselves).
14. Use empathy rather than sympathy.

15. Allow silence when it happens — it is often therapeutic.

16. Cue into the clients feelings rather than words— relate your comments to his/her feelings.
Feedback" is a way of helping another person to consider changing her behavior. It is communication to a person (or a group) which gives that person information about how she affects others. As in a guided missile system, feedback helps an individual keep her behavior "on target" and thus better achieve her goals.

Some criteria for useful feedback:

1. It is descriptive rather than evaluative. By describing one's own reaction, it leaves the individual free to use it or to use it as she sees fit. By avoiding evaluative language, it reduces the need for the individual to respond defensively.

2. It is specific rather than general. To be told that one is "dominating" is probably not as useful as to be told that "just now when we were deciding the issue you did not listen to what others said and I felt forced to accept your arguments or face attack from you."

3. It takes into account the needs of both the receiver and giver of feedback. Feedback can be destructive when it serves only our own needs of the person on the receiving end.

4. It is directed toward behavior which the receiver can do something about. Frustration is only increased when a person is reminded of some shortcoming over which she has no control.

5. It is solicited rather than imposed. Feedback is most useful after the receiver herself has formulated the kind of question which those observing her can answer.

6. It is well-timed. In general, feedback is most useful at the earliest opportunity after the given behavior focusing, of course, on the person's readiness to hear it, support available from others, etc.

7. It is checked to insure clear communication. One way of doing this is to have the receiver try to rephrase the feedback she has received to see if it corresponds to what the sender had in mind.

8. Both the giver and the receiver check with others in the group the accuracy of the feedback. Is this one person's impression or an impression shared by others.

Feedback, then, is a way of giving help. It is a corrective mechanism for the individual who wants to learn how well her behavior matches her intentions are and it is a means for establishing one's identity for answering WHO AM I?

Adapted from University Associates material
HOW TO TALK WITH PARTICIPANTS

ABOUT SENSITIVE SUBJECTS

I. Talking About Death

A. General Issues

1. Expect Resistance - especially if you have never talked about it (for example - your group focused on happy topics)

2. Start Slowly - bring up the subject as it comes up - for example if someone in the program dies, or a relative dies. - This will eventually become a natural part of the group - but it takes time.

3. Death is a part of life - even more so with the elderly. Even if you do not talk about it - it will affect the group. It is better to bring out sad and difficult topics - participants can then further benefit from other parts of the program.

4. Help Participants to help each other - Don't try to "solve" each persons grief yourself - let the participants share coping mechanisms with each other - you can help guide the discussion and encourage others to share.

B. Some Specific Techniques

1. Values Clarification Exercise:
   Have participants discuss this question - each choose one and say why. For example
   "Which of these would be more difficult for you to accept?"
   - the death of a parent
   - the death of a spouse
   - your own death
   make sure to stress there are no right or wrong answers - just each individuals feelings.

2. Memorial Board & Book
   After a participant dies - put their picture on a board - have participants write memories of person - have album with pictures and memories to keep them.

3. If someone expresses emotions: for example crying, anger, etc. Do not stop them if others in the group start to feel uncomfortable - help them to share with the person expressing grief and to share coping mechanisms as above.
APPENDIX 0

BEHAVIOUR RATINGS SCALE

Please indicate how well the following items describe________________________

<table>
<thead>
<tr>
<th></th>
<th>hardly at all</th>
<th>fairly well</th>
<th>well</th>
<th>very well</th>
<th>completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does not take part in family conversations</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>Does not read newspapers, magazines, etc.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>Sits around doing nothing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>Does not show an interest in news about friends and relatives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>Does not start and maintain a sensible conversation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>Does not respond sensibly when spoken to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>Does not understand what is said to him/her</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>Does not watch and follow television</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>Does not keep him/herself busy doing useful things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>Fails to recognize familiar people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>Gets mixed up about where he/she is</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12.</td>
<td>Gets mixed up about the day, year, etc.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13.</td>
<td>Has to be prevented from wandering outside the home</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14.</td>
<td>Hoards useless things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15.</td>
<td>Talks nonsense</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16.</td>
<td>Appears restless and agitated</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>Gets lost in the house</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18.</td>
<td>Wanders outside the house at night</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19.</td>
<td>Wanders outside the house and gets lost</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20.</td>
<td>Endangers him/herself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21.</td>
<td>Paces up and down wringing his/her hands</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22.</td>
<td>Wanders off the subject</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23.</td>
<td>Talks aloud to him/herself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24.</td>
<td>Seems lost in a world of his/her own</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25.</td>
<td>Mood changes for no apparent reason</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26.</td>
<td>Becomes irritable and easily upset</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27.</td>
<td>Goes on and on about certain things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28.</td>
<td>Accuses people of things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>29.</td>
<td>Becomes angry and threatening</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30.</td>
<td>Appears unhappy and depressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>31.</td>
<td>Talks all the time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>32.</td>
<td>Cries for no obvious reason</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>33.</td>
<td>Looks frightened and anxious</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>34.</td>
<td>Gets up unusually early in the morning</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
APPENDIX P

BURDEN INTERVIEW

NAME ____________________________

Please indicate how much discomfort you feel by circling the appropriate number between 1 and 5 for each statement below.

<table>
<thead>
<tr>
<th>not at all</th>
<th>a little bit</th>
<th>somewhat</th>
<th>quite a bit</th>
<th>extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. I feel resentful of other relatives who could but who do not do things for my relative.  
   1  2  3  4  5

2. I feel that my relative makes requests which I perceive to be over and above what s/he needs.  
   1  2  3  4  5

3. Because of my involvement with my relative, I don't have enough time for myself.  
   1  2  3  4  5

4. I feel stressed between trying to give to my relative as well as to other family responsibilities, job, etc.  
   1  2  3  4  5

5. I feel embarrassed over my relative's behavior.  
   1  2  3  4  5

6. I feel guilty about my interactions with my relative.  
   1  2  3  4  5

7. I feel that I don't do as much for my relative as I could or should.  
   1  2  3  4  5

8. I feel angry about my interactions with my relative  
   1  2  3  4  5

9. I feel that in the past, I haven't done as much for my relative as I could have or should have.  
   1  2  3  4  5

10. I feel nervous or depressed about my interactions with my relative.  
    1  2  3  4  5

11. I feel that my relative currently affects my relationships with other family members and friends in a negative way.  
    1  2  3  4  5

12. I feel resentful about my interactions with my relative  
    1  2  3  4  5

13. I am afraid of what the future holds for my relative.  
    1  2  3  4  5

14. I feel pleased about my interactions with my relative.  
    1  2  3  4  5

15. It's painful to watch my relative age.  
    1  2  3  4  5
Burden Interview, cont.

16. I feel useful in my interactions with my relative  
   1  2  3  4  5

17. I feel my relative is dependent.  
   1  2  3  4  5

18. I feel strained in my interactions with my relative.  
   1  2  3  4  5

19. I feel that my health has suffered because of my  
   involvement with my relative.  
   1  2  3  4  5

20. I feel that I am contributing to the well-being  
    of my relative.  
   1  2  3  4  5

21. I feel that the present situation with my relative  
    doesn't allow me as much privacy as I'd like.  
   1  2  3  4  5

22. I feel that my social life has suffered because  
    of my involvement with my relative.  
   1  2  3  4  5

23. I wish that my relative and I had a better  
    relationship.  
   1  2  3  4  5

24. I feel that my relative doesn't appreciate what I do  
    for him/her as much as I would like.  
   2  3  4  5

25. I feel uncomfortable when I have friends over.  
   1  2  3  4  5

26. I feel that my relative tries to manipulate me.  
   1  2  3  4  5

27. I feel that my relative seems to expect me to take  
    care of him/her as if I were the only one s/he  
    could depend on.  
   2  3  4  5

28. I feel that I don't have enough money to support my  
    relative in addition to the rest of our expenses.  
   1  2  3  4  5

29. I feel that I would like to be able to provide  
    more money to support my relative than I am able  
    to now.  
   1  2  3  4  5

(Rejects of the Impaired Elderly: Correlates of Feelings of Burden, Steven H. Zarit,  
Ph.D., Karen E. Reever, MPA/MSG, Julie Bach-Peterson, MSG, Andrus Gerontology  
Center, Univ. of Southern California, Los Angeles, CA.)
SELF CARE: Describe patient as he enters workshop indicating dress, grooming and general appearance.

TASK BEHAVIOR: (Observation, not inferences.)

1. **Decision Making:** Summarize the decision-making behavior considering the following questions:
   a. How does your patient choose and initiate a project?
   b. Does he start one independently?
   c. Does he ask for suggestions? From whom?
   d. Does he wait until the O.T. asks him what he wants to do and/or assigns him a task?

2. **Learning Style:** Summarize the patient's learning style considering the following questions:
   a. What are his methods of learning?
      1. Demonstration
      2. Written materials
      3. Imitation of others
      4. Trial and error
   b. What behaviors indicated this was his learning style?
   c. Did the patient have access to using more than one of these approaches to learning?

3. **Problem Solving:** Summarize the patient's problem solving behavior considering the following questions:
   a. Can your patient identify if he has a problem?
   b. Can he identify what it is?
   c. How does he attempt to solve it?
      1. What does he do on his own?
      2. How does he utilize resources? (People and/or learning materials?)
   d. How does he handle constructive criticism or suggestions?

4. **Goal Directed Behavior:** Summarize patient's goal directed behavior considering the following questions:
   a. How long can he attend to a project?
   b. Can he set his own goal?
   c. Can he identify and implement steps necessary to complete a goal?
   d. Is he able or can he delay gratification until task completion?

5. **Use of Resources:** Summarize the patient's responses to supervision considering the following questions:
   a. When he has a problem to whom does he turn for assistance?
   b. When he gets suggestions does he make use of them? Does he act defensively?
6. **Social Interactions:** Summarize the patient's social interactions considering the following questions:
   
a. Does he seek interaction with staff or other patients?
b. Do others seek him out?
c. What is the content and quality of interaction?

7. **Skill Performance:** Summarize the patient's level of performance considering the following questions:
   
a. Can he recognize the quality of his work?
b. Does he apply proper techniques, exercise care, and interest in the project?

**ASSESSMENT:** Based on the above information identify the patient's strengths and problem areas in basic functioning.
APPENDIX R

STAFF EVALUATION

Rating Scale:

1 = Does not meet requirement
2 = Minimal effort required
J = Modest effort required
S = Strong effort required

II. Leadership Skills

A. Professional attitude

1. Is aware of social environment and social issues; understands implications for practice

2. Recognizes and appreciates uniqueness, including own

3. Understands and accepts role responsibilities

B. Demonstration of practice

1. Is aware of self and implications of self style

2. Ensures client participation throughout treatment, program process

3. Is able to modify assessments, goals and patterns of

4. Knows and uses resources

5. Motivates other staff in performance and training
6. Integrates knowledge from theory, research and experience into practice.

7. Effectively supervises and develops other staff.

II. Communication:

A. Professional

1. Communicates effectively both verbally and in written form.

2. Facilitates active involvement of individuals and groups among participants.

3. Conducts and/or participates in staff meetings.

B. Communication—Overall (Development of knowledge and skill)

1. Constructively manages conflict and difference.

2. Uses supervision for professional development and opportunity for learning.

3. Broadens and deepens own professional development.

4. Able to advocate and assert for professionally relevant client needs.

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III. Follow-Through

A. Work Management (task)

1. Manages multiple work responsibilities effectively.

2. Organizes tasks and levels of involvement to meet efficiency expectations.

3. Takes initiative in the performance and completion of tasks.

90
I. Cooperates with co-workers and supervisors

2. Maintains awareness of overall situation, acts accordingly

3. Willing to share in unpleasant tasks

4. Exhibits responsible behavior in attendance

5. Exhibits responsible behavior in punctuality

IV. Additional Feedback Evaluation and Staff

A. Recommendation:

B. Comments:

C. Points of improvement

D. Plans for Employee Development

Employee Signature

Executive Director
d. A current list with mailing addresses of the Executive Committee or Officers of the Board, if any;

c. If staff have been engaged, a record of satisfactory medical examination of each staff member who will come into contact with the participants and those who will be engaged in handling and preparation of food, (see IV D. 10.);

f. Samples of all forms used such as, but not limited to application forms, agreement forms, etc.;

g. Certificate of Occupancy: The applicant shall provide, where applicable, a copy of a certificate of occupancy from the local building official for each building to be used, as evidence of compliance with the Uniform Statewide Building Code;

h. A sketch of floor plan of the entire building. Exact measurements including floor area shall be submitted.

• Fee: there is no fee for a State license.

• Study of the Application: Following receipt of the application and material requested in G. 2., a representative of the Department will make a study of the proposed services and facilities of the applicant. The Department will request an inspection and report as to the sanitary conditions from the local health department. Where applicable, the Department will request inspections and report as to fire safety from State and local fire officials.

4. Buildings and Equipment

The following provisions are worthy of reference:

• Buildings shall meet State and/or local building codes.

• The facility shall be properly maintained. Both exterior and interior shall be repaired when and where needed and
shall be free from safety hazards. All areas shall be clean. Each occupied room shall have smooth floors and/or carpeting, walls, and ceilings shall be so finished as to enable satisfactory cleaning.

● A licensed day care facility shall provide a minimum allowance of twenty square feet of indoor activity/recreation space per participant.

● All doors and windows shall open and close readily and effectively. Screen doors shall open outward. Outer openings that are regularly used for ventilation shall be effectively screened and open and close readily.

● Before construction has started or contracts are awarded for any new construction, remodeling, or alterations, plans shall be submitted to the Department, the local health department, the State Fire Marshall's office, where applicable, and to the local building official, where applicable, for review and recommendations.

● Rooms extending below ground level shall not be used for participants unless they are dry, well-ventilated and have adequate window space for illumination by daylight.

● Facilities shall be available for those participants who wish to rest regularly or occasionally, or for emergencies. There shall be provision for privacy. Beds or cots shall not be placed in corridors, kitchens, basements or attics.

● Toilet facilities, including handwashing facilities, shall be provided and shall have a minimum of a self-closing door, if they open into a room used for storage, preparation or service of food.

● Where there are men and women, there shall be separate toilet facilities.
• An ample supply of hot and cold water shall be available at all times. Hot water shall be at least 110° F. and thermostatically controlled.

• Grab bars shall be installed by all toilets.

• Heat shall be supplied from a central heating plant or an approved electrical heating system. All rooms used by participants shall be supplied with heat so that a temperature suitable for aged, infirm or disabled persons is maintained.

• All areas shall be well lighted for safety and activities. Recreation areas shall have 50 footcandles of light. All other areas shall have 30 footcandles of light as registered on a light meter.

• Artificial lighting shall be by electricity. Lighting shall comply with local fire and electrical wiring regulations. Approved emergency lighting facilities such as flashlights or battery lanterns shall be provided and available at all times. Outside lighting shall be provided for protection against injuries and intruders.

• Handrails shall be provided on all inside and outside stairs, ramps and elevators. Safeguards shall be provided for hazardous windows, doors, open porches, changes in floor level, and similar accident hazards and shall be acceptable to existing fire and/or building codes. Danger areas on the property outside the building shall also be safeguarded.

• Elevators where used, shall be kept in good running condition and shall be inspected in accordance with State and/or local statutory requirements. A copy of the inspection report shall be made available to the Commissioner's representative upon request.
• Where nonambulatory participants are cared for, doorways and ramps shall permit passage of wheelchairs. Ramp(s) shall be provided at the ground floor.

• A sufficient number of trays, dishes, and flatware shall be provided so that each participant has the necessary utensils and so that food is served attractively.

• Trays, dishes and flatware shall be easily cleanable, safe and shall not have chips, cracks and/or dents.

• Disposable dishes and utensils, if used, shall be used once and discarded, and shall be sturdy enough to prevent them from being a safety hazard.

5. **Fire Protection**

• A day care center shall meet the Virginia Fire Safety Regulations and/or the Uniform Statewide Building Code where they apply as well as any local applicable fire regulations.

• All facilities shall be free from fire hazards as determined through inspections and reported on a form provided by the Department.

• A detailed fire plan shall be worked out for each facility. Wherever possible, this plan shall be drawn up with the advice of the local fire department or fire prevention bureau. This shall be posted in a conspicuous place. The director and all employees shall be fully informed of the fire plan for the facility, including their duties, location, and operation of fire extinguishers, fire alarm boxes, and telephone procedure in calling the fire department. Fire drills for the staff and those participants able to participate shall be held at least quarterly. The drills shall be planned and announced in advance. All participants shall know what procedure will take place
for him/her in case of fire. At the time of orientation for both staff and participants, the details of the fire plan shall be discussed including where the written fire plan is posted. This shall be reviewed at the time of the quarterly fire drills. A permanent record of fire drills held shall be kept in the facility for two years.

- Nonambulant participants shall not be placed in rooms on any floor above the ground level, without approval of the Department.

6. Sanitation and Preventive Health Measures

- The entire premises shall be kept neat, clean, and free from all accumulations of dirt and rubbish and be well ventilated and free from foul, stale, and musty odors. In centers with ten (10) or more participants, Title 35, Chapter 3, Sections 32-35 through 35.42.1, Code of Virginia, and all regulations adopted thereunder shall apply to the provisions of food service facilities and maintenance thereof.

- Adequate provisions for the collecting and legal disposal of garbage, ashes, and waste material shall be provided. Covered, vermin-proof, metal watertight containers shall be provided for garbage, ashes, and waste material. Containers shall be emptied and cleaned at least once a week.

- Premises shall be kept free of flies, roaches, rats and other vermin.

- Infectious waste material shall be legally and sanitarily disposed of.

- Storage space separate from foods shall be provided for cleaning supplies.
• All drinking and eating utensils shall be air dried if a dishwasher is not used. They shall not be dried with a towel.

• The center shall make provisions for the proper washing of bed, bath, table and kitchen linens and other washable goods either on or off the premises. If this is to be done on the premises, it shall not be done in a food preparation, storage, or service area. Soiled bed, bath, kitchen and table linens shall be laundered according to accepted methods of the Virginia Department of Health.

• If cloth napkins are used, they shall be used only once and laundered.

• Tablecloths shall be changed when soiled.

• Fresh kitchen linens shall be provided daily beginning with the first meal of the day.

• There shall be no smoking permitted by personnel while engaged in food preparation and service.

7. Health Care and Supervision

• The director and employees shall not abuse or punish any participant by any method including but not limited to physical force, confinement, withholding food, exclusion from activities, or speaking abusively.

• Special supervision and assistance shall be given to those persons who are unable to keep themselves neat and clean.

• Whenever a participant suffers serious illness or accident, the attending physician, the next of kin or other designated person and/or cooperating agency(ies) shall be notified of such condition immediately. All illnesses
or accidents that occur at the center shall be regularly entered into the participant's record, including what was done by staff and/or where the person was sent for treatment.

- No medical or dietary program or system of medication shall be started or continued without a written order of a licensed medical doctor.

- The medicine cabinet or closet shall be conveniently located, not in the kitchen, and adequately illuminated with 100 footcandles measured on a light meter. All medications shall be securely locked and accessible only to a responsible person in charge. A record shall be kept of all drugs taken.

- A responsible person shall be designated to distribute drugs from the locked cabinet to the proper participant named on the prescription label. For purposes of this requirement, a responsible person is defined as one who is not tempted to use the drugs personally and who is capable of reading the prescription label and distributing drugs to the proper person.

- Only those persons authorized by the State law to administer or dispense controlled drugs shall be permitted to do so. This may include licensed doctors, nurses, physicians' assistants, or other individuals who have met the State requirements to perform these functions. NOTE: An authorized agent of the physician may administer drugs in accordance with such physician's instructions pertaining to dosage, frequency and manner of administration when the drugs administered would be normally self-administered by a participant, as provided by Code of Virginia, Section 54-524.65, as amended.
- If a participant becomes disturbed and unmanageable, the attending physician and the family shall be notified promptly. Methods of physical restraint shall not be used except in an emergency and/or under the direction of the participant's physician or an available physician. A written report shall be filed with the director of the center by any staff member involved in a physical restraint of a participant with a copy of the report being filed in the participant's record. If such a participant does not respond promptly to the treatment prescribed by the attending physician, arrangements shall be made for his removal from the center.

8. **Food Service and Nutrition**

- Each facility shall have a dining area adequate to serve all participants either all at one time or in shifts.

- Catering service, if used shall be approved by State and/or local health department and catered food shall meet dietary requirements set forth in these standards.

- Lunch shall be as evenly spaced as possible between breakfast and supper, never closer than four (4) hours.

- Food and nutritional needs of the participants shall meet dietary allowances as prescribed in printed form by a recognized authority such as but not limited to The Food and Nutritional Board of the Nutritional Research Council, The United States Department of Health, Education, and Welfare, Public Health Service, The Virginia Department of Health, The Virginia Polytechnic Institute Extension, etc., and/or the attending physician's orders.

- If a participant has not had breakfast before coming to the center, breakfast or a snack shall be served soon after his/her arrival.
A menu for snacks and meals shall be planned for at least two weeks at a time and posted. 1) Any changes shall be noted. 2) A record of menus actually served shall be retained for six months.

Religious dietary laws (or practices) of the director shall not be imposed upon participants unless mutually agreed upon in contract with director and participant. The participants' religious dietary practices shall be recognized and respected by the director.

There shall be a supply of staple foods on hand to meet emergencies.

9. Activities

The director shall be responsible for making available programs within the facility that will be appropriate to the needs, interest and abilities of the participants.

Indoor Facilities (Living or Recreational Room): Twenty (20) square feet per participant of living and/or recreational room(s) shall be provided for the participants of the facility for use for visits with each other, with relatives and friends, for small group activities and for larger social events. Included in this area shall be books, magazines, newspapers and games. The dining room may be used for recreational purposes.

Outdoor Facilities: Each facility shall provide for outdoor activities. Such an outdoor area shall be reasonably secluded from traffic noise, and include a safe walk area, and be available to all participants. If a facility has no available space for outdoor activities, staff or volunteers shall be available to escort participants on walks, transport them to nearby parks, etc. No participants shall be confined to indoor activity due to lack of adequate staff or outdoor facilities.
• Activity Program: Activities shall include such things as, but not limited to, the following: arts and crafts for both men and women, music, religious programs, celebrations (for birthdays, holidays, and special events), picnics, library programs, informal social activity, sports activities, gardening, games, trips, card clubs, fishing, discussion groups, etc.

• Volunteers

a. Where volunteers are used in the facility, they shall: be used to enrich the program; have qualifications appropriate to the services they render; and be subject to the same regulations on confidentiality as are staff members.

b. The director or an employed staff member shall be in charge of the volunteer program including the planned orientation to the center.

c. If volunteers are used as regular staff (i.e., assuming staff duties on a scheduled basis), the licensee or director shall enter into a written agreement(s) with the volunteer(s) specifying duties, hours, and any other special considerations such as meals, transportation, etc. The volunteer(s) shall meet all health and personnel requirements for regular staff if so utilized.

d. To limit disruption to the program of the center and disappointment of participants, staff members in charge of volunteers shall determine during the early stage of involvement whether the volunteer demonstrates dependability for a particular assignment.

e. Turnover of volunteers shall be kept to a minimum.

f. The center shall 1) establish requirements for the selection of volunteers; 2) have an agreement between
itself and the individual volunteer, agreeing on the latter's job assignment; and 3) clearly differentiate the volunteer's responsibility from staff members.

• Use of Community Resources: Each director shall avail himself/herself of as many of the various community resources and services as possible to provide a well-rounded activity program for the participants who are willing and capable of participating in them.

All of the standards pursuant to the sections on "General Regulations," "Records," and "Management and Personnel" are in accordance with the policies and procedures outlined in this proposal.
APPENDIX T

Letter to Zoning Administrator

Mr. Phillip Yates
Zoning Administrator
Fairfax County
10555 Main Street
Fairfax, VA 22050

Dear Mr. Yates:

The Alzheimer's Disease and Related Disorders Association of Northern Virginia is interested in exploring the feasibility of developing an adult day care center in Fairfax County. A summary of the proposed program is enclosed for your information.

Central to our determination are the time, costs, and actions required of us by the County zoning requirements. We also understand that the appropriate zoning category is significant to the process requirements.

Can you provide us with information pursuant to these concerns?

Your guidance and suggestions on how we might most efficiently pursue our interests would be most appreciated.

Sincerely,

Lin Noyes
President

Enclosure
Family Respite Center, Inc
2036 Westmorland Street
Falls Church, Virginia 22043

ANNUAL REPORT
June 30, 1984 - June 30, 1985
This year, June 30, 1984 through June 30, 1985, has been an exciting one, filled with challenges and rewards. We have all worked hard to reach our goal of opening a day care center for people suffering from dementing illnesses.

This first annual report summarizes our year's activities and highlights events which have significance for future planning.

We are most grateful to all the individuals and organizations who have helped us during this first year. Their number has been significant and their offerings in talent and gifts have made our accomplishments possible.

Summary of Activities

Several years ago, a family support group of the Alzheimer's organization in Northern Virginia expressed its desire to start a day care center for victims of Alzheimer's-type diseases. In May 1983 a planning committee was named by the Chapter and in July 1983, the first donations from Knights of Columbus, Mount Vernon Council were received. This first donation pushed our dream into the real world. Finding a site for the Center was difficult but finally in June 1984 a home for the Center was found. Reverend John Keating, Bishop of Arlington, offered space in Paul VI High School for one year so that we could open the Center and demonstrate our effectiveness to the community.

On July 13, 1984 a non-profit corporation in the State of Virginia was formed and named the Family Respite Center, Inc.

After several zoning delays we opened our doors on September 27, 1984. We began part time serving three participants two days a week. Gradually our enrollment increased and in April 1985 we opened full time: Monday through Friday, 7:30 am to 5:30 pm.
In June 1985 we averaged 8.1 participants per day having served 34 families during our first partial year of service.

Our efforts to relocate the Center at the end of our year’s lease at Paul VI High School culminated in the move to our new home in the Chesterbrook Presbyterian Church. We are grateful to this congregation for housing us and look forward to a long stay at this site.

The staff has been small, steady, dedicated and flexible, adapting to new care techniques day-by-day. Two of our three staff members have been with the Center since it opened and another part time person was hired after having served as a volunteer. We have had a few employees who stayed for a short period of time. One of them is a graduate student in nursing who will be working with us during the summer.

"Related" Activities

The Center not only provides day care but also strives to educate and support others involved in caring for the memory-impaired. In May a workshop titled "Caring for Alzheimer's Patients" was held for nurses aides, respite companions and others who provide "hands-on" care. It was attended by 26 people who gave the program a "better than average" rating. We have planned a major conference for September 1985, "Right to Respite, Right to Care" for health professionals.

In addition to this formal program, 31 talks were given this year to community groups and university students to teach them about Alzheimer's and the Family Respite Center.

We had 47 new visitors (recorded) come to our Center during the year to learn about Alzheimer's or observe the work of our Center. We also had eight college students come to the Center as part of their educational process. Finally, we were visited seven times by newspapers, television or radio reporters interested in
spreading the word about Alzheimer's Disease. We were noted in USA Today, The Washington Post and The Journal. We were interviewed for local TV, cable and public broadcasting programs.

Hopefully, this media exposure will lead the general public to a better understanding of Alzheimer's Disease and greater awareness of the work of our Center.
ADMISSIONS AND DISCHARGES

Admissions

Between September 27, 1984 and June 30, 1985 34 people were admitted to the Center and came for at least one day of service. Fifteen of these people are still enrolled in the program. Of those admissions 23 were women, 11 were men. Their ages ranged from 48 to 93 with an average age of 73. Eleven came from other day care centers/senior centers, two were referred by social workers, four were referred by doctors and the remaining 17 have been "self" referrals, either through the Alzheimer's organization or media notices. The relationships of the program participants to the caregivers were as follows: 12 were parents, 18 were spouses and four were related in other ways.

The average length of stay for the initial period was 3.69 months, with an average attendance of 2.8 days per week. Although the majority of those attending are ambulatory, two came in wheelchairs and four required assistance of walkers, canes or another person.

Table 1 represents the growth of the Center, month by month and gives the total number of participant days. The last column shows our projection which was made in January 1984. This projection represents the average number of clients per day we expected to serve in order to meet our business "break even" point.

Discharges

There have been 19 discharges for the following reasons:
- Two died suddenly
- Three died after a short illness (less than three months)
- Three "self" discharged by Center relocation
- Three went to nursing homes
- Six returned to care of their families
- One moved to another area
- One went to a home for adults
Only one of the discharges was at the request of the Center; the rest were initiated by families or an event (e.g., family moving). Distance to and from Center and difficulty getting participants to the Center were among the reasons that families withdrew their loved ones from the program.
Scholarships

It is the intention of the Board of Directors that no one be turned away from the Center for lack of funds. This year seven people came to the Center paying less than £22.80 per day. Six received partial reductions in fees and one came for free.

The following shows the amount of money earmarked as scholarship (that is, the collective reduction in client fees for the month due to "scholarship agreement").

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<thead>
<tr>
<th>Month</th>
<th>Amount</th>
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<tr>
<td>September</td>
<td>£45.60</td>
</tr>
<tr>
<td>October</td>
<td>239.40</td>
</tr>
<tr>
<td>November</td>
<td>296.40</td>
</tr>
<tr>
<td>December</td>
<td>198.80</td>
</tr>
<tr>
<td>January</td>
<td>22.80</td>
</tr>
<tr>
<td>February</td>
<td>£250.00</td>
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<tr>
<td>March</td>
<td>433.20</td>
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<td>April</td>
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<td>May</td>
<td>531.20</td>
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<tr>
<td>June</td>
<td>225.60</td>
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</table>

Total for Year: £2,719.90
Looking Ahead

Throughout the next year we will endeavor to bring this Center to a capacity of 20 participants per day and cover program costs through client fees and scholarship donations. We will be investigating staff benefits including health and dental policies. We will be looking to expand our program to include research opportunities and more formal educational programs for families and other caregivers of Alzheimer's patients.

Additionally, we will be looking at ways to expand our services to include short term and long term respite care as well as day care.
### TABLE 1

Client Service Record for Year Ending

**June 30, 1985**

<table>
<thead>
<tr>
<th></th>
<th>Days Opened</th>
<th>Clients Served</th>
<th>Participant Days</th>
<th># of Clients Per Day</th>
<th>Projected # Clients/Day</th>
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</thead>
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<td>0</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>August 84</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>September 84</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>3.0</td>
<td>3.1</td>
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<td>October 84</td>
<td>12</td>
<td>8</td>
<td>32</td>
<td>2.7</td>
<td>2.6</td>
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<tr>
<td>November 84</td>
<td>16</td>
<td>10</td>
<td>61</td>
<td>3.8</td>
<td>3.3</td>
</tr>
<tr>
<td>December 84</td>
<td>12</td>
<td>14</td>
<td>55</td>
<td>4.6</td>
<td>4.2</td>
</tr>
<tr>
<td>January 85</td>
<td>18</td>
<td>14</td>
<td>69</td>
<td>3.8</td>
<td>4.8</td>
</tr>
<tr>
<td>February 85</td>
<td>15</td>
<td>18</td>
<td>96</td>
<td>6.4</td>
<td>6.2</td>
</tr>
<tr>
<td>March 85</td>
<td>16</td>
<td>19</td>
<td>117.5</td>
<td>7.3</td>
<td>8.0</td>
</tr>
<tr>
<td>April 85</td>
<td>18</td>
<td>21</td>
<td>126</td>
<td>7.1</td>
<td>8.2</td>
</tr>
<tr>
<td>May 85</td>
<td>23</td>
<td>23</td>
<td>167</td>
<td>7.6</td>
<td>10.5</td>
</tr>
<tr>
<td>June 85</td>
<td>15</td>
<td>27</td>
<td>122</td>
<td>8.1</td>
<td>13.4</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>150</strong></td>
<td><strong>34</strong></td>
<td><strong>862.5</strong></td>
<td><strong>5.36 (avg)</strong></td>
<td><strong>6.43 (avg)</strong></td>
</tr>
</tbody>
</table>

**Notes:**

- **Days Opened:** The number of days during the month for which the Center was opened to participants.

- **Clients Served:** The actual number of participants we served during the month.

- **Participant Days:** Basic unit of measuring service; one client came for one day of service.

- **Average Number of Clients Per Day:** Participant days divided by days opened for a month.

- **Projected Average Number of Clients Per Day:** This number was used as a basis for budgeting and represents a six percent growth rate per week.
Table 2 is a presentation of the cost of the program month by month. It is clear that as participant days increase, cost per day is decreased. When enrollment reaches 20 clients per day, cost should equal $22.66 per day.

**TABLE 2**

<table>
<thead>
<tr>
<th>Month</th>
<th>Participant Days</th>
<th>Total Expenses</th>
<th>Cost/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>June</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>July</td>
<td>0</td>
<td>58.03</td>
<td>0</td>
</tr>
<tr>
<td>August</td>
<td>0</td>
<td>215.20</td>
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<tr>
<td>September</td>
<td>15</td>
<td>763.87</td>
<td>50.93</td>
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<tr>
<td>October</td>
<td>32</td>
<td>4,937.19</td>
<td>154.28</td>
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<tr>
<td>November</td>
<td>61</td>
<td>4,674.35</td>
<td>76.63</td>
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<td>December</td>
<td>55</td>
<td>3,804.70</td>
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<tr>
<td>January</td>
<td>69</td>
<td>5,044.04</td>
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<td>February</td>
<td>96</td>
<td>1,820.82</td>
<td>18.97</td>
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<tr>
<td>March</td>
<td>117.5</td>
<td>9,137.73*</td>
<td>77.76</td>
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<td>April</td>
<td>128</td>
<td>2,838.86</td>
<td>22.18</td>
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<tr>
<td>May</td>
<td>167</td>
<td>3,874.18</td>
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<tr>
<td>June</td>
<td>122</td>
<td>5,858.69</td>
<td>48.02</td>
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</table>

Total for Year 862.5 $44,021.80 61.43 (Avg cost/day)

Projected 400 $ 9,065.04 22.66

* This month is extraordinarily high because of payday scheduling irregularities and includes legal fees for start-up.
DATE 11/12/85

FAMILY RESpite CENTER INC
GENERAL LEDGER
INCOME STATEMENT
FOR PERIOD ENDED 06/30/85

<table>
<thead>
<tr>
<th></th>
<th>THIS MONTH</th>
<th>RATIO</th>
<th>12 MONTHS</th>
<th>RATIO</th>
<th>THIS MONTH</th>
<th>12 MONTHS</th>
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<tr>
<td><strong>TOTAL INCOME</strong></td>
<td>1,437.29</td>
<td>100.0</td>
<td>97,523.28</td>
<td>100.0</td>
<td>6,710.75</td>
<td>20,920.03</td>
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**STATEMENT**

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<th></th>
<th></th>
<th>THIS MONTH</th>
<th>12 MONTHS</th>
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<td>14,107.12</td>
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<td>64,900.00</td>
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<td><strong>TOTAL INCOME</strong></td>
<td>1,437.29</td>
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<td>97,523.28</td>
<td>100.0</td>
<td>6,710.75</td>
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**EXPENSES**

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<td>0.2</td>
<td>67.10</td>
<td>449.03</td>
</tr>
<tr>
<td>DEPRECIATION EXPENSE</td>
<td>26.01</td>
<td>1.8</td>
<td>26.01</td>
<td>0.0</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FOOD</td>
<td>339.65</td>
<td>23.6</td>
<td>1,097.46</td>
<td>1.1</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>FEES</td>
<td>0.00</td>
<td>0.0</td>
<td>64.00</td>
<td>0.1</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>PAYROLL TAX EXPENSE</td>
<td>791.34</td>
<td>55.1</td>
<td>1,206.00</td>
<td>1.2</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>HOMING EXPENSE</td>
<td>2,031.50</td>
<td>141.3</td>
<td>2,031.50</td>
<td>2.1</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>START UP EXPENSES</td>
<td>261.00</td>
<td>18.2</td>
<td>1,226.49</td>
<td>1.3</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>TOTAL EXPENSE</strong></td>
<td>6,852.81</td>
<td>476.8</td>
<td>144,081.00</td>
<td>45.1</td>
<td>7,601.44</td>
<td>47,122.31</td>
</tr>
</tbody>
</table>

**GROSS INCOME**

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5,415.52</td>
<td>376.8</td>
<td>53,501.48</td>
<td>59.9</td>
<td>14,312.19</td>
<td>68,042.34</td>
</tr>
</tbody>
</table>

---
**AMLY RESPITE CENTER, INC.**

**STATEMENT OF REVENUE, EXPENSES, AND FUND BALANCES—CASH BASIS**

**FROM JULY 13, 1985 (DATE OF INCEPTION) TO JUNE 30, 1985**

### REVENUE

<table>
<thead>
<tr>
<th>Donations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Grants and Large Donations</td>
<td>$64,900</td>
</tr>
<tr>
<td>Scholarship Donations</td>
<td>5,025</td>
</tr>
<tr>
<td>Memorial Donations</td>
<td>598</td>
</tr>
<tr>
<td>Property Donations</td>
<td>4,800</td>
</tr>
<tr>
<td>General Donations</td>
<td>5,892</td>
</tr>
<tr>
<td><strong>TOTAL DONATIONS</strong></td>
<td><strong>81,215</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Revenue</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Fees</td>
<td>14,107</td>
</tr>
<tr>
<td>Fundraising—Net of Expenses of $572</td>
<td>1,597</td>
</tr>
<tr>
<td>Other Income</td>
<td>604</td>
</tr>
<tr>
<td><strong>TOTAL OTHER REVENUE</strong></td>
<td><strong>16,308</strong></td>
</tr>
</tbody>
</table>

**TOTAL REVENUE** 97,523

### EXPENSES

<table>
<thead>
<tr>
<th>Program Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consummables</td>
<td>1,535</td>
</tr>
<tr>
<td>Consulting fees</td>
<td>5,749</td>
</tr>
<tr>
<td>Depreciation</td>
<td>26</td>
</tr>
<tr>
<td>Food</td>
<td>1,097</td>
</tr>
<tr>
<td>Inservices</td>
<td>82</td>
</tr>
<tr>
<td>Insurance</td>
<td>1,654</td>
</tr>
<tr>
<td>Moving Expenses</td>
<td>2,032</td>
</tr>
<tr>
<td>Rent</td>
<td>2,850</td>
</tr>
<tr>
<td>Printing, Postage and Publicity</td>
<td>669</td>
</tr>
<tr>
<td>Salaries</td>
<td>12,133</td>
</tr>
<tr>
<td>Start-up expenses</td>
<td>981</td>
</tr>
<tr>
<td>Taxes-Payroll</td>
<td>646</td>
</tr>
<tr>
<td>Telephone</td>
<td>643</td>
</tr>
<tr>
<td><strong>TOTAL PROGRAM SERVICES EXPENSE</strong></td>
<td><strong>30,097</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supporting Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General Administration</td>
<td></td>
</tr>
<tr>
<td>Legal and Accounting</td>
<td>1,810</td>
</tr>
<tr>
<td>Office Expense</td>
<td>793</td>
</tr>
<tr>
<td>Salaries</td>
<td>7,508</td>
</tr>
<tr>
<td>Start-Up Expenses</td>
<td>245</td>
</tr>
<tr>
<td>Taxes-Payroll</td>
<td>400</td>
</tr>
<tr>
<td><strong>TOTAL GENERAL ADMINISTRATION EXPENSES</strong></td>
<td><strong>10,756</strong></td>
</tr>
</tbody>
</table>

| Fundraising                      | 3,169 |
| **TOTAL SUPPORTING SERVICES EXPENSES** | **13,925** |

**TOTAL EXPENSES** 44,022

**EXCESS OF REVENUE OVER EXPENSES** 53,501

**BEGINNING FUND BALANCES** 0

**ENDING FUND BALANCES** $53,501

See accompanying notes and accountant's report.
UPDATE - JUNE TO OCTOBER 1985

The move to Chesterbrook Presbyterian Church in June 1985 has caused some changes in our planning and budgeting. According to our original plan, the Center would reach capacity in September 1985 after one year of operation. Our growth has continued and in October we averaged 12.8 participants per day (see Table 3), but we have not reached capacity, consequently we have not reached our "break-even" point where client revenues will cover operating expenses. Break-even occurs when 20 clients come and pay $22.80 per day. We have reforecast and now expect to reach capacity in June 1986.

The cost per day figures are shown on Table 4 and illustrate that as our growth continues our expenses have decreased to $30 to $35 per day. The analysis of average gross income between July and October (Table 5) shows that our monthly expenses average $3,000 a month below our income. This money is drawn from savings and currently (as of November 30, 1985) there is a balance of $31,139.44 in this account.

We will continue our efforts to increase enrollment at the Center and continue our efforts to educate others in the care of Alzheimer's disease victims.
<table>
<thead>
<tr>
<th></th>
<th>Days Opened</th>
<th>Clients Served</th>
<th>Participant Days</th>
<th># of Clients Per Day</th>
<th>Projected # Clients/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>21</td>
<td>19</td>
<td>190</td>
<td>9.05</td>
<td>18</td>
</tr>
<tr>
<td>August</td>
<td>22</td>
<td>23</td>
<td>256</td>
<td>11.6</td>
<td>20</td>
</tr>
<tr>
<td>September</td>
<td>19</td>
<td>20</td>
<td>181</td>
<td>9.5</td>
<td>20</td>
</tr>
<tr>
<td>October</td>
<td>21</td>
<td>24</td>
<td>282</td>
<td>12.8</td>
<td>20</td>
</tr>
<tr>
<td>November</td>
<td>19</td>
<td>21</td>
<td>231</td>
<td>12.0</td>
<td>20</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>102</strong></td>
<td><strong>51</strong></td>
<td><strong>1,140</strong></td>
<td><strong>10.9</strong></td>
<td><strong>19.6</strong></td>
</tr>
</tbody>
</table>
TABLE 4

COST PER DAY

Total Expenses/Units of Care (Participant Days)
# TABLE 5

## ANALYSIS OF AVERAGE GROSS INCOME

**July - October 1985**

<table>
<thead>
<tr>
<th></th>
<th>Jul - Oct Actuals</th>
<th>Less Unusual Items</th>
<th>Net Actuals Jul - Oct</th>
<th>Average /Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Fees</td>
<td>$12,890.90</td>
<td></td>
<td>$12,890.90</td>
<td>$3,222.72</td>
</tr>
<tr>
<td>Grants</td>
<td>8,370.00</td>
<td>8,370.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mem Donations</td>
<td>1,175.00</td>
<td>1,175.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genl Donations</td>
<td>1,922.00</td>
<td>1,922.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fund Raising</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Income</td>
<td>4,562.68</td>
<td>4,562.68</td>
<td>$12,890.90</td>
<td>$3,222.72</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>$28,920.58</td>
<td>$16,029.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Salary</td>
<td>$16,644.28</td>
<td></td>
<td>$16,644.28</td>
<td>$4,161.07</td>
</tr>
<tr>
<td>Office Exp</td>
<td>49.56</td>
<td></td>
<td>49.56</td>
<td>12.39</td>
</tr>
<tr>
<td>Printing</td>
<td>541.57</td>
<td>101.00&lt;sup&gt;1&lt;/sup&gt;</td>
<td>440.57</td>
<td>73.42</td>
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<tr>
<td>Postage</td>
<td>304.34</td>
<td>193.00&lt;sup&gt;1&lt;/sup&gt;</td>
<td>111.34</td>
<td>27.83</td>
</tr>
<tr>
<td>Publicity</td>
<td>451.89</td>
<td></td>
<td>451.89</td>
<td>112.97</td>
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<tr>
<td>Misc Exp</td>
<td>6,584.11</td>
<td></td>
<td>6,584.11&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Legal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounting</td>
<td></td>
<td>131.00&lt;sup&gt;2&lt;/sup&gt;</td>
<td>397.47</td>
<td>99.36</td>
</tr>
<tr>
<td>Telephone</td>
<td>528.47</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meal Prep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td>1,481.24</td>
<td></td>
<td>1,481.24</td>
<td>370.31</td>
</tr>
<tr>
<td>Rent</td>
<td>9,236.00</td>
<td>7,236.00&lt;sup&gt;3&lt;/sup&gt;</td>
<td>2,000.00</td>
<td>500.00</td>
</tr>
<tr>
<td>Center Cons</td>
<td>347.61</td>
<td></td>
<td>347.61</td>
<td>86.90</td>
</tr>
<tr>
<td>Part Cons</td>
<td>231.74</td>
<td></td>
<td>231.74</td>
<td>57.93</td>
</tr>
<tr>
<td>Food</td>
<td>2,067.38</td>
<td></td>
<td>2,067.38</td>
<td>516.84</td>
</tr>
<tr>
<td>Payroll</td>
<td>307.67</td>
<td></td>
<td>307.67</td>
<td>76.91</td>
</tr>
<tr>
<td>Start-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>$38,775.86</td>
<td>$14,245.11</td>
<td>$24,530.75</td>
<td>$6,095.93</td>
</tr>
<tr>
<td><strong>Gross Income</strong></td>
<td>($9,855.28)</td>
<td>($11,639.85)</td>
<td>($2,873.21)</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup>Conference and special program expenses  
<sup>2</sup>Telephone installation  
<sup>3</sup>Air conditioning installation
LOSING A MILLION MINDS:
CONFRONTING THE TRAGEDY OF ALZHEIMER'S DISEASE AND OTHER DEMENTIAS

Contractor Documents

Part 3:
Special Care Programs and Facilities

March 1987
THE OTHER TITLES APPEAR ON THEIR OWN INDIVIDUAL MICROFICHE UNDER THE APPROPRIATE CLASS NUMBERS.

Describing a Residential Care Unit for Persons with Dementia, Dorothy H. Coons, Institute of Gerontology, University of Michigan, Ann Arbor, Michigan 48109

The Senior Respite Care Program, Louise Dunn, Senior Respite Care Program, Good Samaritan Hospital and Medical Center, Portland, Oregon 97210

Experiences of the Atlanta Area ADRDA in the Development and Management of the Community Services Program, Carolyn J. French, Atlanta Area Chapter, Alzheimer's Disease and Related Disorders Association, Atlanta, Georgia 30340

The Family Respite Center: Day Care for the Demented, E. E. Noyes and Richard Wittenborn, Family Respite Center, Inc., Falls Church, Virginia 22043

The Family Survival Project, Diana M. Petty, Family Survival Project, San Francisco, California 94115

Evaluation of a 24-hour Care System for Persons with Alzheimer's and Related Disorders, J. Daniel Sands and Judy Belman, Harbor Area Adult Day Care Center, Costa Mesa, California 92627

Institutional Approaches to the care of Individuals with Dementia, Audrey S. Weiner, The Hebrew Home for the Aged at Riverdale, Riverdale, New York 10471

Urinary Incontinence in Alzheimer's Disease, Thelma J. Wells, School of Nursing, University of Michigan, Ann Arbor, Michigan 48109

These are contractor documents that were used in preparing OTA's final Assessment Report. OTA makes these contractor documents available for the use of readers desiring a more detailed or technical discussion of an issue than can normally be accommodated in our final Report. As an OTA contractor documents, they have not been reviewed or approved by the Technology Assessment Board. The findings and conclusions expressed are those of the authors and do not necessarily reflect the views of OTA, the Advisory Panel or the Technology Assessment Board.