evolved more out of the needs of the very service delivery system than out of appraisal of the nature of today's Jewish community and its changing institutional forms.

The sense of community among Jews is strongly felt today more in the fears than in the hopes we hold for each other. A sense of community must be strengthened: a sense of concern and a sense of cultural achievement, using the term culture in its broadest sense. Some coming together of Jews is a pervasive, contemporary need, whatever institutional forms it may take. It is clear that an acceptance of the objective "creating community" would help to put us on the path toward its achievement.

The Mentally Impaired Aged: Reordering Priorities*

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This article discusses some findings out of two projects in the residential care of confused and forgetful aged persons. The article discusses what was learned about giving care and about staff training needs; the challenges that are presented to the institutional system; and some questions about assessment and diagnosis.

THIS article is based upon two specific projects over the past six years, centered in the Special Care Section of the Jewish Home for the Aged of Toronto, in which care to the grossly mentally impaired residents is concentrated.

These residents are recognizable by all geriatric workers. They are diagnosed as having chronic brain syndrome, with *extremely severe impairment* of cognitive function. Most suffer from accompanying illnesses, and a wider range of physical disabilities. Many are in wheelchairs. Few have a steady gait. Some are practically helpless, unable to feed, dress or toilet themselves. These are the residents, average age of 84.7 years, who cannot by themselves manage their daily living. They cannot find their way to the central dining room downstairs or go back to their own room from any part of the building without getting lost and frightened. Most will not remember if they have had lunch; some have even forgotten their own names. Almost all would be incontinent without nursing routines, and even with the routines, some are incontinent of bowel and bladder. Disoriented, and confused, they are unable physically, socially and emotionally to survive without help, and they require continuous supervision and nursing care around the clock.

Some display extreme agitation and restlessness: one woman paces the corridor back and forth, twenty times to the hour; another pulls the buttons from her sweater, and counts out loud; another repeats automatically in her breathing "oi veh" "oi veh"; and another pounds her fist in anger on the table. A man likes to collect little trinkets, and takes them from other people's drawers into his pockets; another woman sits all day with her head and eyes downcast and refuses to budge, except for meals. Types of behavior all too familiar.

Familiar, too, are the problems in delivering care to these residents for which we sought answers in our Project proposal:

1) The disparate views of nursing staff and group services about a resident's responsiveness sounded as if the activity staff were reporting entirely different residents. Cooperation and involvement in group programs contrasted sharply with the difficult and stubborn behaviour with which nursing aides had to deal in the morning . . . and that frightened and timid old woman with whom the social worker was spending so many hours in reassurance, turned out to be a scratcher and a biter! Physical conditions alone did not satisfactorily explain the unevenness of function in these residents, nor the changeability in their mood and comprehension.

2) There was a conviction that many were indeed still capable of doing so

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much more if only we knew how to engage them; and how at other times to sustain the level of functioning they demonstrated in their participation in activity program, but not in the activities of daily living . . .

3) Some family members found it too painful to visit their parent in Special Care, were embarrassed about their behaviour and could not face the deterioration.

4) The stigma attached to Special Care and the mentally impaired resident was widespread and seemed to spill over onto staff: "How can you work there?" and, of course, there were the ever present difficulties which their behaviour presented to nursing in giving them care.

5) Disturbing behaviour of some residents could be controlled by medication. But often this created a drowsiness in the residents that made them unavailable for participation or more susceptible to falls. Some residents needed to be tied into their chairs to protect them from falling and their angry reaction to being restrained in their movement caused them to be more agitated. A woman refused a bath and screamed whenever the nurses tried to change her underpants; when a male resident awoke at night, he would push the bed against his door and refuse to let the nurse into the room.

Our Special Care Demonstration Project funded from July 1969 to March 1973, by the National Department of Health and Welfare of Canada, was concentrated on one Special Care floor comprising 43 residents. The choice of a demonstration, rather than a research project was very deliberate. We wanted to be able to shift gears according to the dictates of practice, rather than be locked into a research format.

Initially this Project was designed to train volunteers in the development and leadership of activity programs with mentally impaired aged residents to effect their maximum participation. We believed that if we could only structure the day with meaningful activity, we could create the continuous, supportive environment they needed, since these residents were so overwhelmingly dependent upon us even for casual social interactions. We hoped to find alternatives to the long hours of sitting, those downcast eyes and the slumping posture, the seeming uselessness of time passing, and that endless pacing back and forth to nowhere.

But as we began to understand more clearly, through our experimentation in programming, the nature of the experience of the mentally impaired, specifically, how they experienced their world — our focus changed in an effort to create with nursing staff a supportive environment tailored more closely to these residents' abilities.

The second Project from which our observations stem — a current training program for staff of Ontario Homes for the Aged working with mentally impaired aged residents, funded in 1973 by the Ontario Ministry of Community and Social Services, is based on the learning derived during the demonstration project. The training is located on the Special Care third floor at the Jewish Home for the Aged. Improvement in the quality of care of their confused and forgetful residents has been documented by the 34 Homes who have participated in the Training Program and provides some validation of what we present today.

I have grouped what I have to report under four major headings:

i. What we learnt about giving care.
ii. What we learnt about staff training.
iii. The challenges this presented to the institutional system.
iv. Some questions raised for assessment and diagnosis.

I. What we Learnt About Giving Care

The demonstration project produced a wide variety of activity programs and learning about techniques for presentation of programs, so that brain-damaged residents could tune in and participate to the best of their abilities; about more effective ways for motivation, and for establishing a sense of continuity with their past experiences and cultural and religious backgrounds; about providing opportunities in the present to use residual skills of the past; about affirming their sense of self and their personal and Jewish identity. We also learned a great deal about the recruitment and training of volunteers for leadership of programs for mentally impaired residents, about their fears and satisfactions and what they needed to sustain them in their work.

Meaning of Behaviour

Of greater significance however, was the understanding of the behaviour and feelings of these mentally impaired residents. Trying to look at experience through their eyes, we realized that for them, with their loss of recent memory, and their disorientation, there really was not any separation between program activity and care. It was a total environment which they struggled to understand and cope with. Since few could ask, or tell, us in words, we had to learn from their actions what they needed and wanted. When we began to understand the signals their actions provided, we began to realize that our prior perception had been faulty. There was meaning in the language of their behaviour — in the tears and screams and scratching and even the repetitive moaning that we'd been told so many times was due to their brain damage. Such behaviour signalled discomfort or distress. We could learn to locate the source of the distress, and in most cases, alleviate it, so that the resident could be more relaxed.

> There was a loud raucous screaming song from the bathing room. Mrs. Shore was being bathed. Her voice was getting louder and the words of the song she was hollering were vehement and angry and I could feel the outrage in her voice. For a deeply religious woman, the baudy lyrics were completely out of character. I asked her why she was shouting this way. She looked at the orderlies. Because she was a very heavy woman who had to be lifted in and out of the tub, it was necessary for two orderlies to assist the nursing aide in giving her a bath. Suddenly, I knew what she meant. For a deeply religious woman to be undressed in front of a man was against all her personal rules of conduct, creating great shame and guilt. The words of the song had expressed her feelings about herself. 'Are you ashamed?' I asked. 'Yes' she said quietly. I asked the orderlies to leave. 'Mrs. Shore, I will make you a promise. We will never put you in the bath again naked, nor will you be naked when you are taken out. I will see to it that you are always covered in the presence of the orderlies who must lift you.' She stopped screaming. The nursing aide helped her wash and a dressing gown was put on before she was lifted from the bath. She has never screamed at bath time since then.

Factors for Change

A number of factors working together contributed towards our learning how to make positive changes in the way care was delivered to these residents. One was the deep conviction of the Charge Nurse, who was coincidentally assigned to this unit shortly before the project began. It was a powerful, profoundly personal philosophy, borne of her own experience in Eastern Europe during the Holocaust, where every older person of a world she knew was no longer alive. She saw in her residents not their impairment, but a precious remnant of another life to be treasured and respected. She regarded them first as old dependent persons needing care. Where we saw confusion, she saw

the fear; where we saw and gauged disorientation, she identified with their loneliness. She paid attention to their human feelings, and sensed their fragile individuality. To her, they needed emotional support to help them live their remaining years, and help to negotiate the immediate environment. This strong determination propelled her and all of us who worked with her, to look beyond the impairment, to uncovering the person inside, to concentrate upon the meaning of their behaviour, so that help could be given to alleviate fear and distress.

Adaptations of Reality Orientation

The second contributor towards change and a dynamic force for training staff was the adaptation to our residential setting, of techniques of Reality Orientation and Attitude Therapy. Currently, Reality Orientation as a behavioural modification technique is very fashionable. What's different about what we are presenting is the *way* we used it to shape our care environment, and the deeper understanding that emerged for us through its use.

Classical Reality Orientation as practiced in mental hospitals is a treatment leading to improvement in orientation, less confusion and discharge.

Changing Reality Orientation from treatment to "a way of life" for the confused and disoriented residents we serve, provided an important undergirding, and a basic framework for looking at difficulties in the care situation. This framework and our Charge Nurse's conviction set us the general goal of shaping the human environment, as distinct from the physical environment, according to the residents' needs. Since the seeming irrational behaviour of Special Care residents had a meaning, this meant searching for what it was in the surroundings to which this behaviour was responsive. What was the resident experiencing in his immediate environment, and in his contact with staff?

As we understood more clearly the difficulties these residents had as a result of their loss of recent memory, in moving from one situation to another, we realized the bridges they needed. In their disorientation, they not only did not know where they were, they did not know where they had been. They needed help from staff to move from the threshold of a program activity back to the corridor of the floor, or even their room, which appeared as a brand new place. Their increased agitation at change of shift in the afternoon could be helped with human support.

> Mr. Smith is always looking for his daughter. We've come to know that when he's feeling most lonesome, he looks for her. Mr. Smith is coming slowly down the hall, hat in hand, leaning on his cane.
> "Hello, Mr. Smith," I say, stopping him.
> "Hello, Hello" he says. "Have you seen my girl?"
> "Are you looking for your daughter, Mary Levine?"
> "Yes" — he looks more closely at me.
> "Do you know my Mary?"
> "Yes," I say. "You know it's only 3:00 p.m., she must still be at work."
> "You mean I can't talk to her?"
> "I mean I don't know her phone number where she works, but after 5:00 p.m., after your supper, she should be home and you could phone her."
> Mr. Smith is becoming more restless — "I don't know what I should do now."
> "Would you like me to show you where your room is?"
> "Yes," and as we walk to the room, he recognizes it, he says "I know where the room is — but I can't talk to *it*!"
> I take his arm: "Would you like to walk down the hall, and sit and talk with someone?"
> "When you don't know anyone and no one knows you, its hard to talk."
> "I know what you mean," I say.
> "My goodness, you could fall down and die and no one would know you."
> "Mr. Smith — everyone here on the Third Floor knows you. All the nurses know your name is Mr. Jacob Smith and that you live on the Third Floor of the Jewish Home for the Aged."
> He smiles — "You know when you tell me — I feel like its a little bit of light coming through to the darkness" and he repeats "when you don't know anyone, you could fall down and die and nobody would know you."
> I repeat — "Mr. Smith, all the nurses know who you are, and when it is time for supper, in about an hour, they will come and invite you to come to the dining room to eat."
> "I feel better," he says. "You mean I can sit and wait for supper soon?"
> Mr. Kaye is coming towards us and I greet him. "Mr. Kaye, do you know Mr. Smith?"
> Mr. Kaye says "of course" and offers a friendly hello.
> Mr. Smith pulls back — and says "what should I talk to him about?"
> "I don't know his work and he doesn't know mine."
> Mr. Kaye interrupts: "I used to be a butcher — and a soldier."
> Mr. Smith: "Oh my, I was a soldier, too."
> "Gentlemen, here are two chairs, would you like to sit and talk before it is time for supper?"
> I left them sitting in lively conversation.

This is an obvious illustration of the need and value of building bridges for the impaired person by means of which he can make connection and cope with his immediate environment. But of equal significance is how it illuminates the depth of feeling of loss and isolation with which the impaired person lives in surroundings he does not comprehend and can't master by himself. *This degree of dependence upon the presence and availability of human connection to enable him to find his footing, is the pathos and challenge of care of the impaired.*

A Tool For Communication

A second way in which Reality Orientation was valuable was as a specific tool for communication.

Who knows what to say to a confused resident, whose jumbled words they cannot understand? The techniques of Reality Orientation became a tool for reaching the residents, of establishing contact with them, and led, as we learned to use it, to a deeper understanding of mental impairment.

Even if she doesn't know what the resident is saying, Reality Orientation gives the nurse something real and concrete to say to him, whether it be "hello, Mr. Smith," or a comment about the time, and its relation to meaningful events like eating, sleeping or visiting. It is a guide that assists the staff member to make a connection with the perseverating person, which is anchored in the here and now, and thus makes the connection genuine and real. It helps to catch his attention, to throw him a lifeline on to which he can grasp to pull himself out of his confusion, or even if not to climb out, to hang onto for security against the frightening isolation.

Thirdly, as a communication tool, Reality Orientation also helped us give concrete help to families through teaching them how to use these techniques in their contacts with their parents. The pain after each visit in saying goodbye was relieved by helping them to attach their parent to the nurse before leaving. The nurse, on the other hand, didn't have to contend with an agitated upset resident who was reacting to the sudden disappearance of something precious to him. Families learned to identify themselves to their parent rather than confront the parent and be confronted, in turn, by the fact that their parent had forgotten their name. It helped the nurses also to use certain specific information about when families would visit that helped reassure or settle residents.

> "Mrs. Samuels constantly asks "have you seen my sister?" She means "when will my daughter visit?" When reminded that this was not her sister, but her daughter, Mrs. Samuels said indignantly "of course I know my daughter Lillie." She continues, however to ask each time for her sister. And each time that she asks, we recognize with

her that she means her daughter, Lillie, and we must remind her *when* Lillie visited last and *when* she will be visiting again. With this information, Mrs. Samuels can be satisfied.

Attitude Therapy

A fourth adaptation was to use Attitude Therapy as a method for training staff, at a deeper level in the individualization of residents. As treatment, a correct attitude for a patient, is prescribed according to his diagnosis. In our "way of life" the appropriate individual approach had to be *developed by the nurses.* They had to find a way in which the resident could accept care being given.

> Mrs. Jones told us how she learned to get along with a very difficult and demanding resident: "I make myself think about the kind of person she must have been — before she got so sick — and not able to do anything for herself. I try to imagine how she must have lived her life, and how she was in her home. She was a politician's wife, and entertained a lot, and had a maid to do things for her. I think she was used to telling people what to do, but I know she wants our respect."

Enlisting the grossly impaired resident's co-operation in daily care can be difficult. At a point of impasse with a resident, to avoid a power struggle, the nurse must be able to back off. To do so with comfort, and not anger or frustration, the nurse must know the supervisor does *not* expect personal care to be given by coercing residents. It is not only whether a bath is given, but also how.

It must be clearly understood that the residents' *feelings* are the prime consideration. Consequently, although avoiding a struggle, the nursing aide is obliged to seek help, to look closer, to try to locate the reason for resident anger and to find a way to prevent resident hostility. The help which she needs must come from her supervisor in encouraging her effort to enlist the resident's cooperation and in helping her find the appropriate approach.

The underlying principle in delivering care is that there is a way that is right for each resident. Through a process of individualization the appropriate way will be found and established as the approach for all staff to take in giving personal care to the individual. The recording on each resident's card of the appropriate approach which was agreed upon and developed by the nursing staff working with the resident, is a protection also for the nurse in her work, as well as for the resident. It provides her with another guideline and help in dealing with difficult behaviour.

Reality Orientation Classes

A fifth adaptation was in the use of half hour Reality Orientation classes. These classes were not considered as a treatment for improving memory, but primarily, as a vehicle for changing staff attitudes about residents, and, secondarily, as a means of stimulation and socialization for residents. The classes were conducted daily by each of the nursing aides and orderlies who worked directly with the residents. This staff see residents in their most dependent and unable moments. As teachers in Reality Orientation classes, they see these same residents in a different role and took pride in their pupils and had time to listen to them.

> "Miss Gabriel had begun to realize that Mrs. Farber understood more than her slow stuttering speech allowed her to say. "She's so accepting of everything, like she doesn't care anymore. I just wish she'd say no to me about something. I'd know then, she was stronger inside. Maybe I could try to get her to point to the dress she wants to wear."

In Summary

To sum up therefore, without negating the importance of other aspects, the fundamental lesson we learnt to value in

giving care was the attention given by the nursing aide and/or orderly staff to the emotional needs of individual residents. Basic was the trust that residents had in them. They were the most significant persons in the environment of these very dependent residents. By their input, their attitudes and their support, by the way in which they interacted with the residents and gave individual care and the information and reassurance which residents needed, they helped them function to the best of their abilities. In general, there was a more relaxed mood, a more comfortable feeling in the unit, with a significant decrease in noise of confusion, and agitation. Individual residents showed reduced anxiety, greater awareness of their immediate environment, increased social functioning and more response and cooperation with nurses in daily routines. Many appeared brighter and more alert; but we did not observe improvement in recent memory function.

The problems encountered in sustaining these positive changes in individual behaviour confirmed our belief that they had been brought about by the environmental support of nursing staff. On those days when a new relief nurses' aide unfamiliar to our approaches in care is assigned to the unit, some of the reactive behaviour of the residents with whom she works reoccurs.

II. What We Learnt About Methods of Training Staff

A human relations component in nursing care cannot be accomplished by lecturing, or by order; good physical care may be obtained by authoritarian method, but not personal interaction with residents, and concerned attention to their psychosocial needs.

> "When I asked Mr. Esperanza how he learned to dress Mr. Bernstein in the morning, so that he no longer shouted for the whole world to hear, he smiled and said "oh, it was easy: I treat him as I would my father in the Philippines. He is a very old, and proud gentleman. He wants to have things his own way. I do not argue with him."

To obtain such involvement of line staff requires paying respect and attention to nursing aides and orderlies as people, to their feelings and opinions and concerns. To be able to use their own sensitive emotional antennae to discern feelings in the resident and reach out to them in their loneliness and fear, means creating a work atmosphere in the unit in which staff feel a sense of their own self worth and dignity. Staff must feel free to invest so much of themselves and be bolstered in their efforts. The resident's expression of satisfaction may only be a smile or nod. Therefore the encouragement and approval and confirmation of the value of their investment from their charge nurse is of special importance.

The Charge Nurse's style of leadership was to seek staff opinions and ideas and democratically involve them in making decisions about working conditions and organization of duties, while never relinquishing leadership responsibilities. She paid attention to the daily nitty gritty details of care that mattered, expecting her staff to work and share together to find a way to enlist resident cooperation and make their nursing job easier; making sure that the workload was 'fair'; ensuring that whatever frustrations could be removed from the work situation were removed; appraising when a resident screamed or shouted and helping the nurse find a way to an approach that was more appropriate; sharing these experiences as a team in order to develop out of discussion nursing care plans which they would follow.

This democratic style of leadership in training staff does not mean the abdication of leadership or responsibility on

the part of the Charge Nurse for the supervision of the staff. On the contrary, an accountability is built into the system in the way in which assignments are made, and expectations set. For example, the setting of work assignments: Each aide or orderly is responsible, daily, for the total care of a particular group of residents for a period of one week; then group assignments are changed. This grouping pattern for care promotes individualization.

The Charge Nurse does insist upon upholding the dignity, of a resident which he is unable to maintain for himself. Precisely because the behaviour of the mentally impaired aged is often not very dignified, a nurse needs help in her perception of the behaviour. Incontinence, spitting, shouting, untidy grooming can be seen as if the person doesn't know any better, or a proof of life-long poor habits.

> Mrs. Stein usually sits quietly, observing, but rarely speaking. She smiles at the nurses when they are helping her and will say "it's nice" or "it's lovely." Whenever she is asked her opinion, she will answer "it's nice" or "it's lovely." If asked to name a familiar toilet article such as a washcloth, she could not, but would repeat her well known phrases, it's nice or lovely. This does not mean, however, that she does not know what a towel is for or how to use it appropriately, or a toothbrush or a bar of soap. She still takes considerable pride in her personal appearance and can manage some areas of self care. But the words for everyday articles are gone. If these items were not within easy reach in the washroom, she would not be able to *ask* for them. And if we did not know, and she did not ask, we might conclude that she no longer knew how to use these basic articles for personal care, or that she did not even know enough to wash her hands when they were dirty.

The rationalization for not treating him with respect is that the grossly mentally impaired resident will not know the difference anyhow. Any breach of respect in attitude of staff towards a resident cannot be condoned. A strong leadership position is necessary to ensure that the dignity is safeguarded. Even the most distasteful behaviour, as smearing feces, can be dealt with in a way to prevent disdain. Here is an example, in the words of the Charge Nurse:

> "Early one morning when I came on duty, I heard Mrs. Wagner call out. Her leg was amputated and she could no longer get out of bed herself. I found her all covered with feces, in her hair and on her face. She was wiping it on the walls, and bedclothes trying to get rid of it. "Help me" "Help me," she was calling.
>
> I worried about the attitude of the nursing aide who was assigned to look after her. When I called the aide to the room I said "look at this poor woman, how she is trying so hard to clean herself from the accident she had early this morning. See how she tries to wipe it off her hands onto anything she can reach! Come we will help her."

III. The Challenges Presented to the Institutional System

This pattern of decision-making of the 'caretaking' team, which differs so much from that of the medical model, presents obvious challenges to administration and the professional hierarchical system.

The more sophisticated the services of the institution, the larger the number of professionals who sit around the conference table hopeful that their deliberation will be helpful to the residents.

> "A long time resident, Mr. Stone, dropped in to chat with the social work supervisor one morning, when it was almost time to be at the Home Staff Conference. She excused herself, explaining that she had to go to a meeting. Mr. Stone looked her squarely in the eyes, and said "These meetings you go to — do they do *me* any good?"

A multi-disciplinary approach is essential for a proper and well rounded planning of institutional care for individual residents. Patient Care Conferences set a structure for such planning,

placing responsibility upon professionals for their respective interdisciplinary roles, involving different departments about new admissions, problems in care and regular review of all residents.

The real challenge lies in translating into practice goals established at the case conference. Patient care conferences, like many "resident councils," may become a *form* for the expression of opinion, but not articulate the *content* of either the residents' or the nursing staff's real need.

To involve the actual care-giving staff in decision-making, many institutions have developed meetings of the direct care staff who work in a unit. If the leadership role in such meetings is taken by professionals who come to educate staff, the most important ingredient for actually involving the staff may be squashed. Meetings where psychiatrists or social workers or other "experts" share their knowledge with staff are appropriate in a continuing educational process. This role however must be supplementary to, but not a substitute for, the direct care staff's own struggles to solve problems they identify.

If nursing staff-aides and orderlies, and their Charge Nurse in the unit are to be the real decision-makers about the delivery of personal care to their residents, then physicians, psychiatrists, social workers, in this area of care, need to serve as resources for the Charge Nurse, rather than as decision-making experts. For most experts, this means learning new role behaviour.

To protect the nursing aide or orderly staff of the unit, while they were engaged in the excitement of discovery, and learning to make decisions, we deliberately, for almost a year, kept professional staff away from the meetings that were held between the Charge Nurse and her staff. In this way, staff had time to gain confidence in their own abilities and participation. The social worker and project director were available to the Charge Nurse at her request for any help she needed in training her staff. In time, the social worker was invited to share information with the staff, as a resource, not as instructor, and to plan cooperatively with them. Finally a regular weekly staff meeting emerged, with both morning and afternoon nursing staff, activity staff, social workers, and nursing supervisor. Much was gained by this structure but sometimes, something essential was lost. It requires a constant vigilance and assertive leadership on the part of the Charge Nurse, to insure that dominant input is not from professional staff, and that the meeting still belongs to the nursing aides and orderlies.

Institutional Hierarchy

Institutions have a way of sending out messages that are in conflict with what's said officially. When we tried to affirm the significant role of the aides and orderlies in giving care, and began to look at the institution through their eyes, we found another value system in operation.

There are many ways in which the institution can reinforce for nursing aides and orderlies that they are the least important members of the nursing hierarchy; not only the lowest paid.

In many Ontario Homes for the Aged, Charge Nurses or registered nurses are not supposed to sit with their own staff or other aides or orderlies at coffee break or at meal time.

Can you count the ways in which the Nursing Department, because of the responsibility charged to it by the board and the administration for safety and well-being of the residents, can undermine the nurses aides' initiative towards helping residents in self care? In the face of risk, to restrain or not to restrain, to walk or not to walk? There is a very powerful drive on the part of ad-

ministrative hierarchy to insist on measures which provide maximum protection for the resident, but coincidentally for administration as well; protections which stop differential treatment and an individualized approach. The administrative hierarchy is very able to protect itself. But, who is left to protect the individuality, the integrity, the feeling of self of the severely impaired defenceless resident?

Clinical supervisors look at wounds, dressings, and will question the Charge Nurse about a resident's temperature, but will not ask why *another* resident is upset, or shouting, or is more agitated than usual.

If supervisory attention is heavily weighted towards physical concerns the Charge Nurse will receive this message. If the resident needs a bath, he gets one, and if the bath cannot be given with his cooperation, it will be given without it, in the best possible way that can be devised, all perfectly justified in the interests of the patient upon which professional standards of care are based.

After a reprimand about the impaction of *one* resident transferred to hospital, everyone was routinely given suppositories, without any regard for individualization of bowel movements. In this way the nurse protected herself to ensure that all the residents evacuated on a routine basis.

This attitude provides no protection for the resident. For the mentally impaired resident, especially, it can be disastrous. It is precisely because of his mental impairment that real danger lurks. Because he cannot be the judge of what is good for him, his resistance or hostility is accepted as part of his impairment: "He's like that! He behaves that way, because he's senile." Such circular reasoning is fallacious.

Physicians sometimes send double messages about having respect for the individuality of a resident and then describing behaviour as "infantile" regression. Such descriptions, for the non-professional who tend to take words more literally, will reinforce negative attitudes about old people returning to their second childhood.

The behaviour of the resident is responsive. It stems from his perception, and reaction to the situation, and to what the nurse is evoking in him by her demand and action. The nurse must be held responsible for the way in which she interacts with the resident, and must be expected to uphold the resident's dignity whether the resident is capable of doing so or not.

On the one hand we appeal to the human feelings of the direct care staff. We talk to, and talk at them. On the other hand, the aide's instinctive feeling for the resident is crushed unless there is an equally powerful commitment in the hierarchy to listen, support, nurture and protect this human response and ensure it has the room to operate.

Supporting this kind of effort and involvement of a nursing aide and orderly staff requires a very different style and method of supervision from that of the traditional clinical nursing supervision which maintains standards of physical care.

Official verbal administrative support of effort is essential but not in itself enough. It is not enough to say "I support your efforts wholeheartedly, go ahead and do your thing." The administration must care and share enough to hold and support the Director of Nursing as she struggles to build in this human relation component down her chain of command. In order to nurture her staff, a Charge Nurse will herself need nurturing, and so will her supervisor, and if she invests herself in the difficult struggle, so will the Director of Nursing. If there is to be the quality of giving in the relationships of nursing aides and orderly staff towards resi-

dents, then this staff have to feel a respect for themselves. If they do not, they will be unable to meet this same need within the resident.

IV. Some Questions Raised for Assessment and Diagnosis

Currently, considerable professional attention is being given to the development of instruments for measuring functional abilities of aged persons.

While it is necessary to pay careful attention to proper diagnosis and assessment for proper institutional placement, some of the most important aspects for the development of appropriate individual care for grossly mentally impaired residents, we have found, can only be realized after placement. Generally, not for several weeks, even months in some cases, do we really get to understand in depth how to best tailor care to meet the individual's need. Each new admission begins again the process of discovery and trying to find the most appropriate way for that person.

Most mentally impaired residents suffering with organic brain syndrome even of a severe nature are more capable of social response and social functioning than they appear to be. In our experience, the use of this capacity by the severely impaired residents is dependent upon the supportive relationship in their immediate environment.

If care patterns are determined by too great a reliance upon prior professional assessments, then, the danger exists that very dependent and inarticulate applicants may be denied opportunity for more meaningful engagement. Much of the problem lies in the nature of mental impairment. Mental deficits of memory loss and diminished intellectual and verbal ability place the elderly with chronic brain syndrome at great disadvantage in assessment procedures which tends to give a measurement of what the individual cannot do rather than that of which he is able, or measure what he has forgotten, rather than that which he still knows. In contrast, the task in designing appropriate individual resident care is to find ways to help him to use his residual skills in daily living, no matter how minimal these may be. The nursing staff who work with him daily must find out for themselves what he can and cannot do, and what, with their assistance he can be helped to do! Finding these means reaching out to establish a relationship with that inner person, the self hidden in the mental "impairment" and inability. Such communication is not at an intellectual but at an emotional level. They must gain his confidence and trust, using their own feelings and human resources for establishment of a relationship. The mentally impaired, because they cannot rely on their memory, tend to rely on their feelings. The yardstick by which we believe we must judge the institutional services we provide for our mentally impaired aged is in the quality of relationships with the nursing staff who give them direct personal care. If these are facilitating relationships, then there will be maximum functioning. At least as much attention needs to be given to an assessment of these relationships as to residents' functioning abilities.

Residents give us messages too, though not always in as loud or clear comment about priorities, as Mr. Goldman, with whose story we conclude. It's a poignant comment upon our perception and treatment of excess disabilities.

> "He'd been a lonely man before he was admitted to the Home. A medical examination showed a hearing loss and after much persuasion, he agreed to be fitted for a hearing aid and it was with much encouragement on the part of the social worker that he learned to wear it. Some weeks later, he came in to her office and threw the hearing aid upon her desk — "Take it," he said, "I don't need it — no one talks to me anyway."