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# Global Perspective

A newsletter for Alzheimer's Disease International (The International Federation of Alzheimer's Disease & Related Disorders Societies, Inc.)

## ADI's 8th International Conference Fulfills Goals —and Adds Color and Excitement too!

"ADI's 8th International Conference in Brussels was superb," the caller said. "The program, the sights and sounds, people will not fully appreciate the experience until after they have returned home." In the weeks that followed, callers to the ADI office echoed the sentiment.

Indeed, from that moment at European Community Headquarters when Belgium's Princess Paola and ADI's President, Princess Yasmin Aga Khan Jeffries, entered the Assembly Room, through to the closing ceremonies in historic Antwerp, it was a colorful kaleidoscope of sights, sounds and events.

From their airport hotels, participants went by bus to Brussels, Leuven and Antwerp for segments of the Conference.

On Friday morning, September 25, 1992, at the EC Headquarters in Brussels, the Opening Session featured a discussion titled *The European Perspective* (on Alzheimer's Disease). In the afternoon, conferees rode out into the countryside to Ferme de Foriest, UCB Pharma's meeting center, for the *Sharing Programme* where ADI Members provided exhibits, and updated fellow members on their organizational progress and program plans.

On Saturday morning, September 26, participants traveled to historic Katholieke Universiteit (Est. 1425) in Leuven, for Parallel Workshops. They walked the lovely tree-shaded campus pathways to sessions on *Basic Research & Genetics; Neuropsychological Assessment; Psychomotor Rehabilitation; Guidelines for Care; Respite Care & Terminal Care*. Late morning

workshops included *Future Strategies & Guidelines for Drug Trials; Health Economics for Home Care; Younger Alzheimer Patients; Residential Care Programs & Services for Caregivers*. In the afternoon, the academic session, *Strengthening the Caregiving Family*, was held in the University's great Sporthal.

Workshops held early on Sunday September 27, focused on *Services for Patients & Caregivers; Dementia & Family Practice; Architecture & Environment; Information Network; and, Organizing a National Alzheimer Organization*. Opportunities to visit Belgian eldercare facilities were also offered.

Then followed a visit to the great Government House in Antwerp for the Reporteurs' Conference Summary and Closing Ceremonies. Afterward, Members visited the magnificent towering gothic style Cathedral of Our Lady (1352-1521) in Antwerp, where a moving ecumenical service was held just for ADI Members and Conference participants, a fitting end to the three-day event.

More on ADI's 8th International Meet-



(l to R) Princess Yasmin Aga Khan Jeffries, Princess Paola of Belgium, Professor Dr. Franz Baro, entering European Community Headquarters.

ing & Conference on these pages and the next issue of *Global Perspective*.

For a copy of the 8th Conference *Book of Abstracts*, write: Belgian Alzheimer Liga; Professor Dr. Franz Baro; Krijkelberg 1; B-3360 Bierbeek; Belgium.

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# About Growth...Challenges... and 1993

Four national Alzheimer societies were added to ADI's membership in September. Today, the International Federation has 27 members—national Alzheimer societies located around the world in:

Argentina	Australia	Belgium
Brazil	Canada	Chile
Denmark	Finland	France
Germany	India	Ireland
Israel	Italy	Japan
Mexico	Netherlands	N. Zealand
Puerto Rico	Scotland	South Africa
Spain	Sweden	Switzerland
United Kingdom	United States	Venezuela

ADI's purposes are directed toward advancing the well-being of persons with Alzheimer's disease, their families and caregivers worldwide. ADI therefore holds an annual international conference to promote the exchange of scientific information and understanding about Alzheimer's disease; it publishes the *Global Perspective*, facilitates networking and exchange of information among members; and currently maintains communications with individuals in nineteen other countries to encourage possible future candidates for membership. In September 1992, ADI entered into an official Working Relationship with the World Health Organization (WHO).



Brian Moss

The development of national societies in new countries is vital to providing needed information and support to afflicted families. However, depressed economic circumstances and cultural differences will impact on the pace at which some national associations are able to form and develop to meet the criteria for ADI membership. Members have expressed interest in supporting nascent Alzheimer societies, and

we have further reason to be optimistic about formation of new societies in light of ADI's new relationship with WHO.

WHO understands the critical need for raising public awareness, promoting training and education, and providing services and support to Alzheimer families, particularly in third world countries. Finding ways to collaborate on these issues will be explored in ADI's relationship with WHO.

In 1993, ADI and WHO will be collaborating: 1) to produce a brochure on caring for a person with dementia, and 2) in providing training for doctors from third world countries.

As we enter 1993, we can share some satisfaction in knowing that concerted effort on behalf of persons with Alzheimer's and their families is now extending well beyond the borders of our own member countries. At the same time, we recognize that there is still much more to be done.

We are fortunate to have our strong and growing ADI membership. We know the work ahead will require added resources of energy, skills, talent—and money. It will be a challenge, but, if I may borrow a phrase from several Alzheimer societies ... *We Can Do it Together*.

Best Wishes for a happy and healthy New Year.

—Brian Moss, Chairman

## Mark Your Calendar

ADI's 9th International Conference  
September 20-23, 1993  
Toronto, Ontario, Canada

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## ADI Council Appoints Deputy Secretary General

Rachel Billington, ADI's part time Deputy Secretary for three years, was appointed by the ADI Council to serve as Deputy Secretary General on a full time basis, effective October 1, 1992.

Originally from Cleveland, Ohio, and a founding member and former President of the Greater Cleveland Chapter of the Alzheimer's Association (USA), she was invited to Chicago to serve as Director of the national office of the Association, in 1982. After establishing basic systems for the Association, her major contributions have been in program planning and development, Chapter Development and Patient & Family Services. She was instrumental in the initiation and develop-

ment of the Association's National Respite Care Demonstration Program.

Prior to joining the Alzheimer's Association, Mrs. Billington worked for nearly twenty years in the health care field in hospital administration and fundraising, patient advocacy and public relations.

Because her father died with a related disorder, she has a keen interest in current research efforts, and believes that wherever Alzheimer's strikes, the devastation, pain, and caregiver needs are the same the world over. "So, sharing information and linking families and caring professionals with existing Alzheimer societies or helping develop new national societies becomes most important," she says.

# Australia's National Action Plan for Dementia Care

At the 8th International Conference in Brussels, Franceska Jordan, President of Alzheimer's Association (Australia), spoke about the Australian Government's recently released National Action Plan for Dementia Care, called *Putting the Pieces Together*. The Alzheimer's Association in Australia has played a key role in the development of this Plan, and will have a close working relationship with the Government in its implementation.

The Plan is the culmination of a successful 21-month campaign conducted by the Association, using its national network of State/Territory Associations and their extensive network of local support groups to lobby key politicians. We began in January 1991, with the publication of a paper calling for a National Task Force on Dementia. This four-page document was divided into four sections: The Need for a National Task Force on Dementia; The Objectives of a National Task Force; Its Structures and Strategies; and its Suggested Terms of Reference.

As well as using our local members to lobby politicians at the local level, an important strategy was to gain the support of key allied organisations, such as the Australian Council on the Ageing, the Australian Association of Gerontology, the Royal Australian and New Zealand College of Psychiatrists, and many oth-

ers. Their letters of support were sent to relevant Federal Politicians and were an effective reinforcement to our campaign.

This campaign fed into a major Review of Aged Care Reform Strategy which the Federal Government conducted from 1991-1992. The first report of this Review was produced in August 1991 and contained a recommendation that the Government produce a National Action Plan for Dementia Care for Australia. Our Association was frequently consulted in the development of the Plan, which was launched by the Federal Minister for Aged, Family and Health Services at the same time as he launched the opening of our National Alzheimer's Week on September 7, 1992.

Although we did not achieve exactly the response we wanted – i.e., the establishment of a National Task Force – our Association is pleased with the Federal Government's reaction, particularly bearing in mind the severe recession we are currently experiencing in Australia.

The Plan allocates an additional A \$31 million (US \$21 million) over five years. The Association heralds the Plan as a welcome first step towards a comprehensive system of care for people with dementia and their carers. It is also worth noting that the Federal Government has already allocated an additional A\$89 million (US

\$59.7 million) in 1992 to a "carers' package," which will also benefit carers of people with dementia, primarily by providing new or expanded respite programs. The main features of the Plan are:

- Improved diagnosis and assessment through local Aged Care Assessment Teams;
- Increased counselling services for family carers;
- Community care and residential care demonstration projects to promote best practice in dementia care;
- Development of a national training program for family carers;
- New training initiatives for community care and residential care workers;
- Four new research fellowships;
- Funding support for the National Secretariat of the Alzheimer's Association (Australia), and the conduct of National Alzheimer's Awareness Weeks.

Franceska Jordan has been asked to prepare a paper for ADI's 9th International Conference in Toronto, Canada (September 1993) which will include an explanation in more detail of the tactics used by the Alzheimer's Association (Australia) in its campaign. Further details on the Plan will be included in this paper.

—Pat Jones, Executive Director  
Alzheimer's Association (Australia)

## Declaration of Rights for Younger People with Dementia and their Carers

*This declaration (distributed at the workshop on Younger Persons with Alzheimer's) was originally prepared for and on behalf of people with dementia under pensionable age in the Mersey Regional Health Authority (U.K.).*

**1. Full informed medical assessment.** General Practitioners should have the relevant skills to recognize the symptoms of dementia in all age groups and be aware of the need to refer on to appropriate consultants.

**2. Recognition of the need for specialist services.** Identification of consultants with special responsibilities for this group of people who will make a diagnosis where possible and from whom carers are entitled to ongoing medical supervision.

**3. After diagnosis,** carers should have access to the following services organized on at least a sub-regional basis:

**Specialist day care services** organized in a flexible way so that carers can continue to work. The aim should be for appropriate stimulation with an emphasis on constructive occupational therapy for those who are able to benefit from it and, for those who cannot, diversional activities. Within the service should be properly funded resource centres providing comprehensive and accurate information and counselling, and support for carers with a drop-in facility.

**Appropriate residential care** when required—not elderly persons' homes or acute psychiatric establishments.

**Implementation of care programmes and case management** so that services are assessed at the time of need, enabling a progressive build-up of care as the person's health deteriorates.

**4. Access to welfare benefits:** Easy access to welfare benefits currently available plus some new benefits:

- A specialist carers' benefit.
- A benefit equivalent to mobility allowance, payable to people with dementia irrespective of age.
- Universal acceptance of Alzheimer's disease as a 'terminal' illness irrespective of age.
- Money to provide care for the person in the community on the scale now available to pay for residential care.

**5. Retrospective reinstatement of rights and benefits** for people who have had to terminate their employment either voluntarily or through dismissal and who have later been diagnosed as having dementia and who have consequently been discriminated against. Employers should be directed to recognize dementia as a reason for early retirement so that pension rights and other benefits are not affected.

**6. Appropriate training and information** to be made available at all levels for public and professionals alike, including GPs.

## Spotlight on Two 8th Conference Presentations

### Reducing the Agitated Behavior of AD Patients Through a Low Intensity Exercise Program

••**A Workshop on Psychomotor Rehabilitation:** Research has documented the prevalence of agitated behavior and the resulting care difficulties among nursing home patients, especially those with Alzheimer's disease (AD) patients. One study found that 93% of nursing home residents manifested one or more agitated behavior at least once a week, while another study reported that among 127 patients with probable AD, agitation was present in 10% of mild, 27% of moderate, and 38% of severe dementia cases. Causes and remedies for agitated behavior are not well known and usually vary from one study to another and among many other factors including inactivity and boredom.

Since the sources of these findings were anecdotal, and unverifiable, a quasi experimental study was designed with two

purposes: (1) to evaluate an exercise/movement program's impact on agitated behavior of patients with AD; and (2) to describe a program of physical activity suitable for an institutionalized population with AD. Twenty-two AD patients participated in a 40-minute exercise/movement study for 28 days. The program was divided into a 10-minute warm-up phase, a 20-minute exercise/movement phase, and a 10-minute cool down period.

Results indicated that most participants claimed they felt better, lost weight, slept better at night, and had fewer digestion problems. The results further showed that the exercise/movement program reduced the agitation behavior of AD patients by almost one-half. The study establishes that an exercise/movement program is both feasible and desirable for AD patients, and



such a program will successfully reduce some adverse behavior.

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### Helping Hand Plus: Reaching Out to Long Term Care

••**A Workshop on Residential Care Programs.** Background: The Helping Hand founded in 1984, is a dementia-specific social model/volunteer model day center and in-home program for persons with Alzheimer's Disease and related disorders. The philosophy of care is based on accepting each person with Alzheimer's as an adult with feelings and a valued human being regardless of disability. This philosophy also recognizes the need for therapeutic programming and individualized care consistent with a person's life story. Families that have experienced improvement in the quality of life of their family member in the Helping Hand Program, have been distressed to find this quality of care missing once their loved one has been placed in a long term care facility.

Identified problem: Often, activities and therapeutic programming, appropriate for memory-disabled persons, simply do not exist in long term care facilities. If activities are provided on a limited basis, for a mixed population, there is not an adequate staff/resident ratio to provide in-

dividualized care and, thus, persons with Alzheimer's are often excluded. This problem becomes even more acute in the facilities on the weekends.

Project Description: Helping Hand is composed of three different projects all relating to improving the quality of care of memory-disabled persons in long term care facilities: 1) The Helping Hand day center model has been replicated in a long term facility where no organized dementia-specific activities had been available. The program operates three times a week, one of which is always Saturday. The volunteer director, a former Helping Hand family caregiver, assisted by other volunteers, conducts the structured program; 2) Eligibility criteria were revised to allow residents of long term care facilities to attend Helping Hand Center. This provides a 'window to the world' by providing an outing for nursing home residents to maintain social contacts and participate in dementia-specific activities; and 3) The Helping Hand in-home program now sends volunteers

into long term care facilities to provide companionship and therapeutic activities to persons with Alzheimer's. The volunteers serve as an "extra family member" or "substitute family member" for long distance caregivers.

Result: Replication of the day center model is a successful and ongoing project. The long term care facility was reluctant at first to accept the disruption to its schedule. Now, they say that the program has helped to change the quality of care provided by the facility in general. The other two projects, extensions of the Helping Hand day center and in-home program, have related in a special way to eight different nursing homes. These efforts have made a difference in dementia-specific care in long term care facilities. It is hoped this is only the beginning.

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## Another Perspective on Caring

*The following article was printed in the Chicago Sun-Times newspaper, on June 18, 1992, and is reprinted with permission from Jeffrey Zaslou.*

The first stage of motherhood may be the most magical. A newborn doesn't know who you are, but needs your love—and love pours out of you naturally. A baby is dependent on you, but incapable of saying thanks. It doesn't matter. No thanks are necessary.

Eileen Carrier recalls her earliest days as a mother. At age 81, she is reliving that first stage of motherhood. But this time around, what was once magic is now tragic.

Her 60-year-old daughter, Donna Webb, has Alzheimer's disease. Donna can't talk, control her bowels or recognize her loved ones. Who knows what she's even thinking? And so Eileen has many flashbacks to the days Donna was a baby.

"When she's being diapered, I think, 'Oh my, how many times did I do this for you in the past?'" Eileen says. "When I push her in her wheelchair, I think of all the times I pushed her in a baby buggy. She was a good baby.

Eileen remembers Donna as a placid child, a good-natured teen and a fun-loving adult. Eileen always assumed that when she got old, her daughter would be there to look after her. She never imagined she'd be an octogenarian caring for Donna.

There are about 4 million Americans with Alzheimer's, a disease that steals your ability to think. Donna is one of the younger victims, and Eileen is one of the oldest caregivers.

Eileen, a widow living in Elgin (Illinois), says she has no choice but to accept her fate. "Feeling sorry for yourself, that's bad news. Then you lose control. I'm doing what comes naturally. I spend my days with Donna and try to help her.

Donna first showed signs of Alzheimer's in 1980, at age 50. She'd say, "What's the matter with me? I can't think." She got forgetful. She'd write checks and forget to fill in the name. Eventually, she had to quit her secretarial job and stop pursuing her passion—raising show cats.

In 1983, Eileen decided to move to Illinois from her home in Florida to help care for Donna. "I got my own apartment,

and I'd go to her house every morning at 6," Eileen says. "I'd stay all day until Donna's husband came home from work. Then he'd take over until morning.

Donna was incontinent and spent much of her day pacing. If Eileen wasn't watching, she'd head out the door.

When Donna's husband died in 1988, more of the burden fell on Eileen. A year later, Donna had to be moved into a nursing home, where she now sits, all day, with her fists clenched and her arms across her chest.

Donna's four children try to help, but two live out of town and the others have kids and jobs. "They do as much as possible," says Eileen. "But, basically, it's me."

Eileen spends much of her life at the nursing home—feeding Donna, making sure her diaper rash is under control, just keeping her company. It has been three years since Donna recognized her.

Eileen attends Alzheimer's Association meetings. The other people she meets there are around Donna's age. They're caring for their ill parents, who are Eileen's contemporaries. Though Eileen recog-

nizes the irony of her situation, she tries not to let it consume her.

At age 81, Eileen is understandably apprehensive about the future. She has heart problems and wears a pacemaker. "I often think to myself, 'I hope the good Lord takes Donna before me,'" Eileen says. "Donna isn't living. She's just a body. And I know her kids will do what they can, but they don't have the time to do what I'm doing."

When Donna was healthy, she used to say that if ever her mom got sick, she'd welcome her into her home and take care of her. Eileen remembers that promise, and in a way, it's comforting.

"Yes, it's heartbreaking as things turned out," Eileen says. "Donna looks right through me, and it kills me. But you have to figure there's a reason for everything."

When I tell Eileen that her efforts and her attitude are inspirational, she quickly dismisses my comment. "I'm not a hero. No way," she says. "I'm just a mother."

*First reprint of this article appeared in the newsletter of the Chicago Chapter, Alzheimer's Association, (USA).*

## Opening Session at European Community Headquarters



(Clockwise from left) Dr. J. Sampaio-Faria, Regional Director for WHO; L. Onkelinx, Belgian Minister of Health; Michael H. Coote, Chair, Alzheimer Europe & Alzheimer Society of Ireland; Professor Dr. Franz Baro, 8th International Conference Organizer & Medical Advisor of the Belgium Alzheimer Liga; Brian Moss, ADI Chairman, R. Chanterie, Member, European Parliament; and photographer.

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# Focus on Quality Care . . .

Assuring quality care for persons with Alzheimer's disease is a matter of deep concern for Alzheimer societies around the world. Highlighted on these pages are summaries of two presentations at the workshop on guidelines for quality care held during ADI's 8th International Conference

**1** *Myra Schiff, PhD, Director of the Guidelines for Care Project for the Alzheimer Society of Canada summarizes her workshop presentation as follows:*

It is estimated that 300,000 Canadians currently have Alzheimer's disease, and this number is expected to increase to 700,000 by the year 2020. Over half a million are expected to be severely incapacitated, requiring a high degree of care.

Despite the number of Canadians with Alzheimer's, and the profound effect the disease has on the individuals, their caregivers and on the Canadian health and social service system, there has been no mechanism for promoting a coherent and consistent direction about care for Canadians with Alzheimer's disease.

The Alzheimer Society of Canada has responded by developing guidelines for care of people with Alzheimer's disease and their caregivers, with the assistance of a three year grant from the Seniors Independence Program, Health and Welfare Canada. The Project is the responsibility of the Guidelines for Care Committee, which reports to the national Board of the Alzheimer Society. Committee members come from across Canada, and include older adults, family caregivers, and members of several relevant professions, including nursing, social work, physical and occupational therapy, and a chaplain.

Canadians with Alzheimer's disease—and their caregivers—live in a wide variety of situations. Many live at home with a family caregiver, while others live in long term care settings such as a nursing home. Many of those living in the community receive personal care, nursing care and homemaking services from community agencies, and some also attend day programs.

The quality of resources and the ease with which they can be accessed varies a

great deal across the country. Large urban areas are likely to have a greater number and variety of services than are small towns or rural areas. The variety is increased further by the fact that each of the ten provinces is responsible for health and social services for its residents.

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***“The challenge was to develop guidelines for individuals with Alzheimer's disease and their caregivers regardless of the circumstances under which they were living.”***

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The challenge was to develop guidelines for individuals with Alzheimer's disease and their caregivers regardless of the circumstances under which they were living. The guidelines needed to be relevant to people living in long term care settings as well as those living in the community. They needed to be appropriate for Prince Edward Island—the smallest province with about 130,000 residents—as well as for Ontario, whose 10,000,000 residents represent just over 1/3 of the Canadian population.

The project began with a Needs Assessment to identify any existing standards or guidelines and topics to include in the guidelines. Visits were made to long-term care settings (such as nursing homes) and

to agencies (such as day programs) providing care for people with Alzheimer's disease living in the community. A report summarizing those visits identified a number of areas in which guidelines would contribute to quality of care for people with Alzheimer's and their caregivers.

Beginning with a first draft, several revisions of the Guidelines were developed by Committee members in the Spring of 1991. A later draft was circulated in the Spring of 1992 to over 70 interested individuals (including family caregivers, staff and administrators from long term care settings and community agencies, family physicians, and representatives from provincial and local Alzheimer societies). Comments from the review were incorporated into the final document, printed and distributed in the Fall of 1992.

The Guidelines deal with the areas of training, education and support for caregivers, assessment, care planning, programs and activities, human resources, environmental design, transportation, decision-making, prevention of and response to abuse, and the use of restraints. They emphasize principles and goals, rather than rules and directions, within each of these areas.

The Guidelines recognize that all older adults are entitled to high quality care, and address those aspects of care which are in addition to the needs of other older adults. They deal with those aspects of Alzheimer's disease which have unique implications for the proper approach to care.

For example, the guidelines focus on the unique aspects of involving people with Alzheimer's disease in the decision-making process, because their mental status raises some problems about competence that do not exist for those who are cognitively intact. They assume that people with Alzheimer's disease will re-

—Continued on Page 10

# 2

Jo Ellen Wicht, MSW, ACSW, is Director of the Alzheimer's Care Center, and Social Services, at Foxwood Springs Living Center, Kansas City, MO. She is a member of the Patient Care & Family Services Committee of the national Alzheimer's Association (USA), and summarizes her presentation as follows:

## GUIDELINES FOR DIGNITY: GOALS OF SPECIALIZED ALZHEIMER/DEMENTIA CARE IN RESIDENTIAL SETTINGS

The Alzheimer's Association in the United States has been involved and interested in special dementia care units for many years. In 1987, the Association funded the first major research study of special dementia care units. The five state, three year study, provided considerable insight in describing the complexity of this developing field. In 1989, the booklet, *Selecting a Nursing Home with a Dedicated Dementia Unit*, by Mace and Gwyther was published by the Association as a guide for families.

The text of this booklet is being updated and will be available in early 1993. A patient and family services bibliography and other materials have been made available as responses to the growing number of requests, and now the Benjamin B. Green-Field National Alzheimer Library and Resource Center is open to better serve the public with information.

A number of chapters have also been involved in co-sponsoring conferences and developing booklets and information on special care units.

Need for *Guidelines for Dignity* became more and more evident as both the Association's national office and chapter offices fielded growing numbers of calls from families and providers with questions about special dementia care units.

In July 1992, the *Guidelines for Dignity* were released. The intent of this document is to define the dynamic process we call "specialized Alzheimer/Dementia care" for those with primary degenerative dementia or Alzheimer disease. With this beginning it is our hope to:

- encourage research,

- build a coalition of interested and involved groups and individuals,
- continue discussion of what components and characteristics should be considered in an effort to provide the best care, and
- build practical methods and strategies for implementation throughout the system

The Association seeks to encourage, support and research innovative models and programs so that "specialized Alzheimer/Dementia care" will continue to evolve and improve in the future.

This document proposes and describes eight goals for action which were created to serve as a guide and benefit providers, Alzheimer/Dementia unit residents and families. The goals follow the chronological process for placement and care as experienced by families.

### GOAL 1: PHILOSOPHY

A specialized Alzheimer/Dementia care program has a written statement of its overall philosophy and mission which reflects the needs of residents afflicted with dementia.

### GOAL 2: PRE-ADMISSION

There is an effective process, for placement in the program, by which diagnosis is verified, the needs of the person with dementia are assessed, involvement of family is recognized (to the desired extent of the individual family) and appropriateness of the facility is confirmed.

### GOAL 3. ADMISSION

The person with dementia is admitted to the program in a convenient and supportive manner, and the family is able to complete the admission requirements in a timely fashion.

### GOAL 4. CARE PLANNING AND IMPLEMENTATION

The plan of care and its implementation is resident oriented, flexible and inclusive of family; and it is intended to promote individual dignity, optimum health and well being and to maximize function of the person with dementia.

Care provision is the responsibility of the interdisciplinary team, committed to

creating a living environment that enhances quality of life for residents and families.

### GOAL 5: CHANGE IN CONDITION

As the disease moves to late stages, the plan of care evolves and is responsive to changes in the individual's condition. A specialized program demonstrates commitment to assist families over the full course of the disease.

### GOAL 6. STAFFING PATTERNS AND TRAINING

All staff, including administrators and non-direct care staff (e.g. housekeeping, dietary, maintenance, volunteers), who work with residents and families in the specialized Alzheimer/Dementia program receive the support of an ongoing training program.

### GOAL 7: PHYSICAL ENVIRONMENT

The physical environment and design features support the functioning of cognitively impaired adult residents, accommodate behaviors and maximize functional abilities, promote safety and encourage independence of residents.

### GOAL 8: SUCCESS INDICATORS

The program is involved in efforts to evaluate the benefits of their specialized Alzheimer/Dementia care.

This document is offered as a beginning point—preliminary goals and guidelines for action that providers of specialized Alzheimer/Dementia care can use as a guide. These guidelines are in no way meant to be the final word, the definitive answer to a very complex and developing field. The guidelines are an invitation to join the partnership of those interested in providing and improving specialized Alzheimer/dementia care in residential settings.

For a copy of *Guidelines for Dignity: Goals of Specialized Alzheimer/Dementia Care in Residential Settings*, write or call: Alzheimer's Association (USA); 919 N. Michigan Avenue; Chicago, Illinois 60611. Tel: +(312) 335-8700. Fax: +(312) 335-1110. \$5.00 USD, Plus Postage & handling.