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SPECIAL CARE UNITS: RECREATIONAL ACTIVITIES FOR
PATIENTS WITH ALZHEIMER'S DISEASE

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Christina Marie Erickson-Taube

June 2005


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PATIENTS WITH ALZHEIMER'S DISEASE

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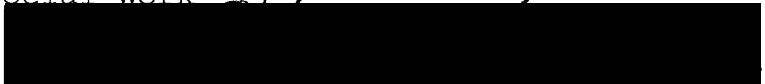
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June 2005

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ABSTRACT

The prevalence of Alzheimer's Disease continues to increase as the aging population increases. As a result, special care units designed for Alzheimer's Disease patients are also growing dramatically. Recreational activities provided for those patients are essential to improving quality of life. A study of 19 special care units using a questionnaire was conducted to identify recreational activities provided. Findings indicated that the more educated a staff member reported to be, the fewer recreational activities were offered. The study also illustrated which activities were more common. Social workers are a significant part of the staff of most agencies serving the aging population.

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I want to thank Dr. Rosemary McCaslin, Dr. Susan Goldstein and Tim Thelander.

DEDICATION

Dedicated with love and thanks to Philip, Marie, Melissa, Tina, Laurie (Cee Cee), Bill, Heidi, Dudley, Melodie, Larry and my friends at C.A.R.E., Inc. - who have watched and shared, and loved and supported me with humor, encouragement, and infinite patience. For their love and eternal support, I am profoundly grateful.

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CHAPTER ONE

INTRODUCTION

This chapter will discuss the prevalence of Alzheimer's Disease and the effects it has had on long-term care. The importance of recreational activities and the effects of those activities on patients with Alzheimer's Disease will also be described. This is an important issue for social work practice because social workers are often the professionals dealing directly with the Alzheimer's patient and their families.

Problem Statement

As our society continues to age at an increasingly high rate, the number of people with some form of dementia has also dramatically increased. It is estimated that Dementia or Alzheimer's Disease is present in 50-70% of all residents in nursing homes today (Peppard, 1986). "Alzheimer's Disease affects as many as one out of every six people over the age of sixty-five and at least one out of every four people over the age of eighty. Alzheimer's Disease is responsible for over fifty percent of nursing home admissions. With respect to the above statements, a staggering number of elderly with mild to

severe impairments, perhaps 10-20 million, can be expected in the next 30 years, representing a huge human and economic toll" (Stehman, Strachanm, Glenner, Glenner, & Neibauer, 1996, pg xi). Washington policy makers have speculated that Alzheimer's Disease may become an "epidemic" in decades to come (Peck, 1998).

"Alzheimer's Disease is the most common of the dementing illnesses; more than 60 percent of those with dementia have Alzheimer's Disease. Alzheimer's Disease is not normal aging, and there is still no proven treatment or cure available" (Stehman, Strachanm, Glenner, Glenner, & Neibauer, 1996, pg xi). Alzheimer's Disease is a serious and rising problem that presents an enormous burden to patients, their families, the community and the national healthcare system.

The estimated annual cost of Alzheimer's Disease exceeds 100 billion dollars. This cost includes medical/nursing care, personal care and social services. This figure suggests that Alzheimer's Disease is the third most expensive disease in the United States (Hamdy & Turnbull, 1998).

Alzheimer's Disease is a complicated disease that affects the brain. It affects predominantly elderly

people. Alzheimer's Disease is a form of dementia. Dementia is a term used to describe a group of brain disorders that cause memory loss and a decline in mental function over time. Doctors, scientists and researchers continue to make steady progress in understanding the ways in which Alzheimer's Disease affects the brain and effective preventions and treatments for the disease. The cause is still unknown.

Institutions providing care to people with Alzheimer's Disease have evolved from state mental hospitals, county sanitariums, and private boarding homes to an industry of more than 16,000 mostly private nursing homes (Lacey, 1999). As nursing home staff and administrators have become more aware of the prevalence of dementia among nursing home residents and their particular needs, separate units have been created. These special care units are designed to assist the cognitively impaired residents maintain maximum independence, dignity and skills. "Approximately 50% of long term nursing home admissions in the United States are accounted for by individuals with progressive dementia or Alzheimer's Disease. Clearly, the number of nursing home admissions, as well as the percentage of dementia residents is

expected to increase as the United States population ages. There are now more than 1,000 Alzheimer Special Care Units providing care to several thousand dementia residents" (Hudgins, 1998, pg 377).

The unpleasant course of a dementing illness takes away a patient's ability to do familiar things, such as dressing oneself or remembering family names. Individuals with Alzheimer's Disease require activities that are specifically designed to keep them functioning at the highest level possible. Although many individuals are resistive to participating in such activities, they are essential to promoting and improving their quality of life.

The use of a recreational therapist in the care and treatment of patients with Alzheimer's Disease is often limited by the availability of therapists and financial or insurance coverage for services. The services are not always available locally and Medicare does not cover these services for patients with a primary diagnosis of Alzheimer's Disease. The basis for Medicare's denial of coverage is that the patient cannot be rehabilitated in traditional terms (Hughes, 1998). This study evaluated special care units in the Inland Empire and the

recreational activities provided for patients diagnosed with Alzheimer's Disease.

Purpose of the Study

The purpose of this study was to evaluate the recreational activities provided in special care units located in the Inland Empire. A questionnaire was developed, which contained various questions regarding the recreational activities provided for patients with Alzheimer's Disease. Once data were analyzed, activities most commonly used were determined.

The population that this study sought to assist was patients diagnosed with Alzheimer's Disease and living in an Alzheimer's special care unit. The questionnaire was addressed to the social service practitioners that coordinate recreational activities for those patients. The research design was a quantitative survey, (i.e., yes or no responses to questions about specific recreational activities).

Participation in recreational activities promotes the dignity, strengths and abilities of a demented patient. Patients with dementia share universal human needs: physiological support, safety, independence and

The findings of this study will assist social workers in caring for Alzheimer's patients. The role of a social worker in special care units is often times to coordinate effective recreational activities for demented patients in various stages of the illness. As a result of this stimulation, the quality of the residents' lives will be promoted. Appropriate recreational activities have the potential to increase self-confidence and self esteem of patients suffering from Alzheimer's Disease, chronic illness or pain.

As the aging population continues to increase, many more people will be diagnosed with a dementing illness, resulting in more people in long term care facilities or special care units. A social worker has the responsibility to advocate on behalf of their clients. Therefore, it is a social worker's responsibility (in addition to other healthcare professionals) to provide recreational activities to assist patients in functioning at an optimum level. By doing so, social workers have the opportunity to improve the quality of care for patients with Alzheimer's Disease.

For activities to be successful, a high level of training and multidisciplinary programming is needed. The

structure of the social environment (or milieu) may also reduce agitation and behavior problems such as wandering, suspicion, paranoia, hallucinations, delusions or perseveration (William & Trubatch, 1993). It is also important that recreational activities address the patient's personal and psychosocial needs.

"Social work education is taking a leading role in identifying the problems of the elderly and is developing gerontological specializations within the curricula. Social workers are a significant part of the staff of most agencies serving the elderly. Many states are now requiring that each nursing home or special care unit employ a social worker, depending on the number of residents" (Zastrow & Kirst-Ashman, 2001, p. 624). Social workers providing services to Alzheimer's patients and their families in a variety of settings must be knowledgeable about the disease, its effects on individuals and families, and appropriate resources.

The assessment stage of the generalist model will be informed. Social workers and other staff that coordinate recreational activities may have to review the activities they provide and may use the results of this study to determine what activities to offer. In assessment, the

generalist practitioner identifies the client's occupational needs and goals. The generalist social worker uses the knowledge and understanding, gained from research, to improve the quality and effectiveness of the services provided to the elderly.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter reviews the literature regarding Alzheimer's Disease, special care units for patients with Alzheimer's Disease and recreational activities in those special care units. It is important to look at how each is connected and necessary to improving the quality of life of those diagnosed with dementia and Alzheimer's Disease.

Alzheimer's Disease

"The history of Alzheimer's Disease began in 1906 with Dr. Alois Alzheimer's presentation of the clinical case of a 55 year old woman suffering from progressive dementia" (Sambat, 1998, p. 51). Some of her problems included very poor memory and a tendency to get lost in the asylum. She suffered from some language impairment, including difficulty finding the right words, and her comprehension was impaired. She also showed symptoms of paranoid delusions and auditory hallucinations. Dr. Alzheimer was unable to identify any neurological deficit. Her motor power was good, sensations were

normal, and all the tendon reflexes were present and within normal limits.

Within four and a half years of the onset of the symptoms, the woman died. Dr. Alzheimer performed a postmortem examination and found that her brain was much smaller than the average brain of people of the same sex and age. He also noticed that the ventricles (cavities normally present in the brain) were dilated and significantly larger than he had expected. A microscopic examination revealed a reduced number of brain cells and numerous neurofibrillary tangles and senile plaques. These findings encompass the characteristic features of Alzheimer's Disease (Sambat, 1998).

An estimated 4.5 million Americans have Alzheimer's Disease. The number of Americans with Alzheimer's has more than doubled since 1980. The number of Americans with Alzheimer's Disease will continue to grow, by 2050 the number of individuals with Alzheimer's could range from 11.3 million to 16 million (Herbert, Scherr, Bienias, Bennett, & Evans, 2003). A person with Alzheimer's Disease lives an average of eight years and as many as 20 years or more from the onset of symptoms (Office of Technology Assessment, 1987). Increasing age

is the greatest risk factor for Alzheimer's. One in 10 individuals over 65 and nearly half of those over 85 are affected (Evans et al., 1989).

Ernst and Hay (1994) suggests that the national direct and indirect annual costs of caring for individuals with Alzheimer's Disease are at least \$100 billion, according to the estimates used by the Alzheimer's Association and the National Institute on Aging. Alzheimer's Disease costs American businesses \$61 billion a year, according to a report commissioned by the Alzheimer's Association. Of that figure, \$24.6 billion covers Alzheimer health care and \$36.5 billion pays for expenses related to caregivers of individuals with Alzheimer's Disease (Koppel, 2002).

"Today, an estimated 1.5 million Americans suffer from severe dementia, meaning that they are so incapacitated that others must care for them continually" (Office of Technology Assessment, 1987, pg3). The estimated average individual cost for nursing home care is \$42,000 per year (Rice et al., 1993) but can exceed \$70,000 per year in some areas of the country. The estimated lifetime cost of care for an individual with Alzheimer's Disease is \$174,000 (Ernst & Hay, 1994).

A report commissioned by the Alzheimer's Association concludes by 2010, Medicare expenses for an individual with Alzheimer's Disease are expected to increase 54.5 percent, from 31.9 billion in 2000 to \$49.3 billion. Medicaid costs for residential dementia care will increase 80 percent, from \$18.2 billion to \$33 billion in 2010, (Alzheimer's Association, 2001).

"A cure for Alzheimer's Disease is still far off and clinicians face the burden of caring for patients at all stages of dementia for the foreseeable future. Those with advanced Alzheimer's Disease suffer neurological symptoms that include incontinence, problems with gait and mobility, cognitive, language and functional impairment and behavior problems" (Tariot, 2003, p. S305).

Alzheimer's Special Care Units

While the effectiveness of special care units for individuals with dementing diseases is currently the subject of considerable debate, there is little doubt that the number of facilities providing such care continues to grow dramatically (Sloane et al., 1995). In an effort to improve the care provided to residents with Alzheimer's Disease, the Philadelphia Geriatric Center in

1974 opened a treatment unit specially designed for those persons. Early in the 1980's a few nursing homes opened special care units for Alzheimer's residents. That movement has become a growth industry. Of the total number of 1.6 million nursing home residences, 720,000 provide dementia residential care (Williams & Trubatch, 1993, p. S20).

Many nursing homes have designated areas or units exclusively for people with Alzheimer's Disease or related dementias. These special care units have become common, based on the idea that those residents with Alzheimer's Disease require specialized care. The goal of special care units is to provide an environment that enhances individualized care and effective approaches to difficult behaviors often associated with dementia. Characteristics of special care units may include specially selected and trained staff, a physical design that promotes mobility, safety, enjoyment and specially designed recreational activities or occupational therapy.

The physical design, programs, staffing and staff training of traditional nursing homes often fail to meet the needs of cognitively impaired residents. Alzheimer residents in nursing homes need security, dignified

personal care, appropriate mental and physical stimulation, and protection from exploitation or abuse (physical and financial). Wandering, poor impulse control and combativeness are among the many changes in behavior, function, personality and mood of Alzheimer patients for which many staff members are often unprepared for and ill equipped to handle.

"Care providers should set specialized goals to help patients with Alzheimer's achieve levels of greater comfort and less frustration, improved affect and socialization, better skills in activities of daily living, good strength, mobility, nutrition and general physical health" (Berg et al., 1991, p. 1230).

Tariot (2003) states that "the concept of long term care includes a wide range of personal, social, environmental, medical and nursing services. There are more than seven million elders in the United States using long-term care services now, and it is estimated that 43% of people aged 65 and older will need long-term care at some point in their remaining lives, although only 1.7 million are in nursing homes at present" (p. S306). Special care units emphasize not only basic medical and physical needs but also the importance of activity

programs and quality interaction between staff and residents (Martichuski, Bell, & Bradshaw, 1996). The National Alzheimer's Association (1994) has estimated that there are over 1500 special care units housing over 50,000 residents with dementia. As the number of older adults with dementia in nursing homes continues to increase, so do concerns about the availability of quality of age and stage appropriate activities for residents.

Recreational Activities for Patients with Alzheimer's in Special Care Units

"Activity programs common in traditional nursing homes, based on new learning, precise directions, current events discussion, or resident councils, are usually inappropriate for memory impaired persons. Care methods are proliferating, yet innovative techniques appropriate for dementia care are not fully developed. It is difficult to develop and test new models of dementia specific care in large integrated facilities that attempt to provide appropriate care for all residents. Large settings confuse patients with dementia, worsen their behavioral symptoms, and conflict with their needs for supervision and cuing" (Berg et al., 1991, p. 1229).

"Individuals with advanced Alzheimer's Disease can no longer initiate or engage in meaningful activities such as hobbies on their own or attend to stimuli such as books or television, and they lack the ability to initiate social engagement. Consequently, they need environmental structure and stimulation. Virtually any daily activities have the potential to be therapeutic, and patients benefit from engaging in as many of these as possible" (Tariot, 2003, p. S308). Participation can improve depression and diminish agitation, apathy and perseverative speech. One-to-one attention, although optimal, is often not possible, especially in a nursing home. Group activities include directed discussion groups, music therapy, pet therapy, and multisensory stimulation (Volicer, McKee, & Hewitt, 2001). Alzheimer's patients may also benefit from interacting with others and participating in activities that stimulate pleasant, comforting memories.

"Keeping patients involved in a meaningful activity is the primary therapy in a recreational program for persons with Alzheimer's Disease or Dementia. Their primary disability includes the inability to plan, initiate, remember or carry out activities by themselves.

If left alone, the Alzheimer's patient may just sit, become agitated or restless, or perform repetitive, meaningless activities. Patients can maintain some control on their life in a meaningful way if care providers assist them through activities and choose appropriate activities based on careful assessment of an individual's history of interests, habits, support systems, emotional state and behavioral problems" (Stehman, Strachan, Glenner, Glenner, & Neubauer, 1996, p. IV:2).

Meaningful activities are activities residents can engage in that produces a positive result for them, either by making them feel they have done something well or by simply making them laugh. Some examples include role playing or sing-a-longs. For giving residents a sense of accomplishment, tasks that are specific to the individual resident are successful (Simard, 2002).

There are many different stages that a person with Alzheimer's Disease goes through. It is very important to recognize a patient's strengths at the various stages of Alzheimer's Disease and to plan activities accordingly. To do this it is important to look at what a person can do instead of what they can no longer do. Participation

in activities can be passive or active. A person may only observe or watch an activity. Other persons may participate in an active way. Some activities may occur in a group situation or be done independently. For example, a person may enjoy quietly watching the birds outside a window or bowling in the dining room.

When providing group activities, there may need to be the opportunity for small group activities. Activities can include life skills, which mean participating in their daily skills. They can be encouraged to help hold a toothbrush, a washcloth or an item of clothing. This could also include mealtime activities like folding napkins or setting the table. Allowing patients to help with watering the plants, dusting or folding the laundry are activities that are just as important as bingo (Alternative Solutions, 2004).

Recreational activities foster community spirit and provide patients a sense of responsibility, cooperation and belonging. Specialized care plans should be used to incorporate a patient's interests and lifestyle into a daily care routine. For example, a former accountant had pencils and paper for "calculations" and a former nurse

walked with the supervisor on daily rounds (Crane, 1985, p. 560).

Recreational activities, including occupational, physical, art and music, may enrich the quality of care provided by the special care unit. The opportunity for activities involving exercise therapy or physical exertion has been proven to be important for persons with dementia because many are still physically able. Exercise may decrease a patient's restlessness, agitation and wandering behaviors. In addition, exercises offer a great opportunity for group recreational programs. Activities involving art may offer an opportunity for creative expression and tangible accomplishment (Office of Technology Assessment, 1987). Other activities found to improve the quality of life for patients with Alzheimer's Disease were activities including animals, gardening clubs (Minkove, 2001) cooking and music.

Contradicting the above mentioned studies, Rabinovich and Cohen-Mansfield (1992) suggests that there is much speculation as to whether elderly nursing home residents suffering from dementing disorders should be exposed to structured recreational activities. Loew and Silverstone (1971) argue that participation in structured

activities provides, at best, only minimal benefit during the activity period especially to those who are in the later stages of dementia. Others argue that exposure to activities, at the very least, provides stimulation that enables demented patients to maintain their abilities for as long as possible (Rabinovich & Cohen-Mansfield, 1992).

Theories Guiding Conceptualization

Alzheimer's affects the person with dementia, the caregiving staff, the family and the community. Thus, systems theory guides the care an Alzheimer's patient receives. Long-term care includes a wide range of personal, social, medical and nursing care. Insurance coverage is also a consideration when placing an individual in a special care facility. The impact of Alzheimer's Disease on individuals, families and the healthcare system makes the disease and needed interventions (such as recreational activities) one of our nation's greatest medical, social and economic challenges.

Summary

The existing research suggests that recreational activities promote well-being and quality of life for

patients in Alzheimer's special care units. Therefore, this study reviews the activities provided in Inland Empire Alzheimer's special care units. The data collected reviews the prevalence of recreational activities. Results will assist social service practitioners in planning appropriate recreational activities in order to strengthen the dignity and respect of the demented person.

CHAPTER THREE

METHODS

Introduction

This chapter will discuss the research design and describe the study's sample. It will also illustrate how the data were collected and the instrument used to collect data. Statistical tests used to organize and present the data are also described.

Study Design

The purpose of this study was to explore the variety of recreational activities offered to patients diagnosed with Alzheimer's Disease in special care units. The choice of recreational activities was very important. By using a variety of activities matched to the person's abilities, the Alzheimer's patient will be able to enjoy his or her current skills and abilities. By providing significant activities, self-confidence and self-esteem are promoted.

The research method used was a questionnaire that listed twenty-five recreational activities deemed appropriate by the Alzheimer's Association of Los Angeles (Appendix A). The questionnaire simply inquired as to

whether or not the special care units provided those specific activities to their Alzheimer's patients. The response to each question was either "yes" or "no."

The following factors may limit the generalizability of the findings of this study. The sample size (n = 19) was small. Special care units are a select population in the Inland Empire. Additionally, it was not possible to control the honesty of the participant's responses. The questionnaire may have lacked additional beneficial recreational activities found to be appropriate by other sources.

Sampling

The data were obtained from Alzheimer's Special Care Units listed in Senior Alternatives for Living (2003) and New Lifestyles, the Source for Seniors (New Lifestyles Inc. (2003). The selection criterion was nursing homes with Alzheimer's special care units. This sample was chosen because both senior publications offer a large area guide for senior residences, care options and services.

Twenty-nine Alzheimer's special care units were identified for participation in the study. Nineteen

special care units responded. A questionnaire was mailed to the social service practitioner in charge of coordinating recreational activities for patients with Alzheimer's Disease at each facility. A follow-up telephone call was made to ensure the receipt of the questionnaire.

Data Collection and Instruments

The questions referenced 25 recreational activities and asked if the special care unit provided each activity. The level of measurement was nominal (0 = no, 1 = yes) (see attached questionnaire, Appendix A). The dependent variable was the recreational activities. The independent variables included the age of the residents, the resident to staff ratio, the level of education of the social service practitioner and the amount of experience of each social service practitioner. The level of measurement for these items was ordinal and nominal.

The questionnaire was created in order to present a list of recreational activities deemed beneficial for the Alzheimer's patient by the Alzheimer's Association of Los Angeles. In order to pretest the questionnaire, it was administered to a local nursing home in Mentone, CA. This

nursing home's responses were not included in the final research project's data.

Procedures

The questionnaire was mailed to the selected Alzheimer's Special Care Units. Included was a cover letter explaining the purpose of the study and discussing the issue of confidentiality (see Appendix B). Included in the cover page was a designated line to mark, to validate that the participants understood the procedures and consented to participating in the study. A debriefing statement was also including (see Appendix C). After three weeks had lapsed, those facilities that had not returned their questionnaires were contacted via the telephone. The data were collected within one month's time.

Protection of Human Subjects

Although individual people were not studied, the anonymity of the participating special care units was protected. Units were not identified in project reports, nor were the social workers responding. Research details were not discussed informally with family, friends,

colleagues or representatives from the media. After the study was concluded, research data were destroyed.

Data Analysis

Using SPSS for Windows, descriptive statistics, such as percentages and frequencies were used to answer the research question. Correlation analyses were also used to compare the frequency of recreational activities. The Independent Sample T-Test procedure was used to compare the means of different variables. Frequency distribution tables and graphs were also found to be effective ways to summarize and present the data.

Summary

This chapter discussed the research design and provided a description of the population sampled. The chapter illustrated the statistical tests used to organize and present data. This chapter also provided a brief overview of the questionnaire used to obtain the data.

CHAPTER FOUR

RESULTS

Introduction

The results of this study will be discussed in this chapter. The data were analyzed using SPSS for Windows. A variety of statistical procedures were used to analyze the data in the study. Variables will be defined and tables summarized.

Presentation of the Findings

The sample included nineteen special care centers (N = 19). Of the twenty-five recreational activities examined, each facility provided a minimum of eighteen activities and a maximum of twenty-four activities. Table 1 (Appendix D) compares the mean and standard deviation of the twenty-five recreational activities presented in the questionnaire. The mean was 21.68 and the standard deviation was 1.57 for the descriptive statistics of the total number of recreational activities offered by the nineteen special care centers.

Table 2 (Appendix D) illustrates the percentages of special care centers that reported not offering each specific recreational activity. For example, 68.4 % of

the special care centers surveyed did not offer activities consisting of the sorting of buttons or coins. Forty-eight percent did not offer activities that included clay. Forty seven percent did not offer activities that included meal preparation.

All nineteen facilities provided the following activities: drawing, singing, walks in/around special care unit, dancing, reading magazines, aerobic activity, activities involving picture books, card playing, old movies, arts and crafts, household chores, activities incorporating family members and religious activities.

The independent t-test compared the mean number of recreational activities for the independent variable, age range of patients that reside in the special care center. The variable age range was divided into two categories: youngest and oldest. "Youngest" was defined as having age ranges of "50-70" and the "oldest" was defined as "71-100." This was found to be not significant as $t = .923 (17), p = .369$. The means tested were 22.0 for the youngest age range and 21.3 for the highest age range. Table 3 (Appendix D) shows the results of the test.

Correlations examined the following independent variables: patient to staff ratio, amount of education the subject had, the number of years the respondent had coordinating recreational activities, the age of range of patients and the number of patients residing in each special care center. Table 4 (Appendix D) indicates that the more experience the special care center's respondent had, the less education they had. As the age range of patients increased, the amount of patients decreased. No correlation was found between the patient to staff ratio and the respondent's level of education.

Table 5 (Appendix D) reveals that the level of the respondents' education is negatively correlated with "score" or the number of activities offered. In other words, the more educated the staff member was reported to be, the fewer the recreational activities provided at their special care center.

Summary

The data were analyzed using SPSS for Windows. A variety of statistical procedures were used to analyze the data in this study. The study found that the higher level of education a respondent had, the fewer

recreational activities were provided at their special care center.

CHAPTER FIVE

DISCUSSION

This chapter will review the findings of this study and discuss the previous research. This chapter will also summarize the limitations and provide recommendations for future studies.

Of the twenty-five recreational activities examined, each facility provided a minimum of eighteen activities and a maximum of twenty-four activities. All nineteen facilities provided the following activities: drawing, singing, walks in/around special care unit, dancing, reading magazines, aerobic activity, activities involving picture books, card playing, old movies, arts and crafts, household chores, activities incorporating family members and religious activities. The research suggests that providing recreational activities to patients with Alzheimer's Disease is a very important part of treatment. These findings are congruent with past research.

Activities that were most often not provided include sorting buttons or coins, activities involving clay, food preparation and folding laundry. This may be because due

to the complexity of these activities and patients being too demented or incapacitated to participate in such activities.

The study also found that the higher level of education a respondent had, the fewer recreational activities were provided at their special care center. This may mean that respondents with more education may have more administrative responsibilities and, as a result, do not spend a lot of time coordinating or providing recreational activities.

The study indicates that the more experience the special care center's respondent had, the less education they had. This may be because respondents gained their knowledge in the field versus in the classroom.

As the age range of patients increased, the number of patients decreased. This may be attributed to more older patients becoming sicker and either passing away or requiring a higher level of care. No correlation was found between the patient to staff ratio and the respondent's level of education.

The study of the recreational activities was consistent with previous research as evidenced by the number of activities offered at each special care unit.

Providing the best possible care for residents with Alzheimer's Disease and dementia is a significant challenge. The findings suggest that special care units are offering recreational activities to their residents, thus attempting to improve their quality of life. None of the previous research indicated a relationship between the amount of education of staff coordinating recreational activities and the amount of recreational activities offered.

Limitations

The sample (N = 19) was small and compromised the validity of the study. A wider variety of recreational activities could have been examined within the survey and the survey could have provided the opportunity to include activities not listed. Additionally, the number of special care units specializing in the care of individuals with Alzheimer's Disease was very small. Future research may want to explore a larger geographical area.

Recommendations for Social Work Practice, Policy and Research

Future recommendations include examining a larger number of special care centers and the possibility of expanding the study to examine special care centers throughout Southern California or even nationwide. Additional research may also include working directly with the Alzheimer's Association to study the recreational activities they advertise as being effective and appropriate. Social workers and social service staff should stay current on therapeutic activities and the effect activities have on the growing number of individuals suffering from a dementing disease. It is also important for special care administrators and social service practitioners to remember the importance of recreational activities when coordinating care.

Conclusions

In conclusion, the results of this study have strong ramifications for all special care centers and social service staff providing recreational activities to patients with Alzheimer's Disease. As the Alzheimer's Association of Los Angeles suggests, as Alzheimer's Disease progresses, there are fewer and fewer times when

the patient has a chance to do something he/she enjoys and feel good about themselves. Activities can help individuals feel good about themselves by changing the focus to things he/she can do and enjoy. It is clear that recreational activities are an important part of a treatment plan and that special care units are providing appropriate activities. This study may lead to further research related to the improvement in quality of care for those diagnosed with Alzheimer's Disease.

APPENDIX A
QUESTIONNAIRE

QUESTIONNAIRE

Please circle the appropriate response.

- | | | |
|--|-----|----|
| 1. Does your facility provide activities involving paints? | Yes | No |
| 2. Does your facility provide activities allowing residents to draw? | Yes | No |
| 3. Do you encourage your residents to dance? | Yes | No |
| 4. Are activities involving singing or sing-a-longs provided? | Yes | No |
| 5. Are activities involving musical instruments offered? | Yes | No |
| 6. Are activities offered involving ton-toxic clay? | Yes | No |
| 7. Are residents encouraged to take walks? | Yes | No |
| 8. Are residents provided exercise or aerobic activities? | Yes | No |
| 9. Are residents provided the opportunity to look through or read magazines? | Yes | No |
| 10. Are residents provided the opportunity or assistance with looking through picture books? | Yes | No |
| 11. Are residents provided the opportunity or assistance with looking through photo albums? | Yes | No |
| 12. Does staff read the local newspaper or magazines to the residents? | Yes | No |
| 13. Do residents take part in simple card games? | Yes | No |
| 14. Do residents sort buttons or coins? | Yes | No |
| 15. Do you provide "old movies" for your residents to watch? | Yes | No |
| 16. Are offsite trips offered? | Yes | No |
| 17. Are gardening activities provided? | Yes | No |
| 18. Are residents encouraged to participate in simple household chores? | Yes | No |
| 19. Are arts and crafts activities provided? | Yes | No |
| 20. Are residents encouraged to prepare food? | Yes | No |

- | | | |
|--|---------|----------|
| 21. Are residents provided the opportunity to color in coloring books? | Yes | No |
| 22. Are religious services offered? | Yes | No |
| 23. Are residents encouraged to participate in self-care activities (i.e. bathing, applying make-up)? | Yes | No |
| 24. Are residents encouraged to fold linen or laundry? | Yes | No |
| 25. Are activities involving family members coordinated (i.e. birthday celebrations, anniversaries)? | Yes | No |
| How many Alzheimer's patients reside in your special care unit? | _____ | |
| What is the age range of patients with Alzheimer's Disease residing in your special care unit? | _____ | |
| How many years of experience do you have coordinating recreational activities for patients with Alzheimer's Disease? | _____ | |
| Please circle your highest level of education: | | |
| High School | College | Graduate |
| What is the patient to staff ratio in your special care unit? | _____ | |

APPENDIX B
INFORMED CONSENT

Informed Consent Form

My name is Christina Erickson-Taube and I am a Masters of Social Work Student at California State University of San Bernardino. I am researching Alzheimer's disease and recreational activities for my graduate thesis. The purpose of this study is to determine if particular recreational activities are provided to Alzheimer's patients in local nursing homes.

The questionnaire contains thirty questions and will take about ten minutes to complete. The questionnaire should be completed by social service staff or other designated staff that coordinates activities for the Alzheimer's patients. Participation is voluntary. The Department of Social Work's sub committee of the Institutional Review Board of California State University, San Bernardino has approved this research project.

The responses to this questionnaire are confidential. Data collected will not be used for any other purpose. Please mark and date where appropriate to acknowledge your agreement to participate in this study. Please complete the following questionnaire, as it pertains to your facility. After completion, please return the questionnaire in the enclosed self addressed stamped envelope. You have the right not to participate and there will be no consequences. You have the right to withdraw you participation and your data from this study at anytime without penalty. If you have any questions or concerns about this study, please contact Dr. Rosemary McCaslin, Faculty Supervisor at 909-880-5507.

Mark

Date

APPENDIX C
DEBRIEFING STATEMENT

Debriefing Statement

Thank you for participating in this study. After completion, please return the questionnaire to Christina Erickson-Taube in the enclosed self addressed stamped envelope. I am researching Alzheimer's disease and recreational activities for my graduate thesis. The purpose of this study is to determine the range of recreational activities available to patients with Alzheimer's disease in local nursing homes. The responses to this questionnaire are confidential. The Department of Social Work's sub committee of the Institutional Review Board at CSUSB has approved this research project.

If you would like the results of this study, please visit the PFAU Library located at California State University of San Bernardino @ 5500 University Parkway, San Bernardino, Ca 92407 or contact Christina Erickson-Taube at ericksonchristina@hotmail.com. If you have any questions or concerns about this study, please contact Dr. Rosemary McCaslin, the Faculty Supervisor. Her telephone number is 909-880-5507.

For information on appropriate recreational activities for patients with Alzheimer's disease, visit <http://www.alz.org>.

APPENDIX D

TABLES

Table 1

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
score	19	18.00	24.00	21.6842	1.56534
Valid N (listwise)	19				

Table 2

Activities Not Offered

Recreational Activity	Facilities That Do Not Offer
Sorting buttons or coins	68.4%
Clay	47.7%
Food preparation	47.4%
Laundry	42.1%
Coloring books	36.8%
Musical Instruments	26.3%
Offsite trips or outings	21.1%
Paints	15.8%
Activities of daily living	10.5%
Gardening	5.3%
Newspapers	5.3%
Photo albums	5.3%

Table 3

Group Statistics

Age Range		N	Mean	Std. Deviation	Std. Error Mean
score	youngest	10	22.0000	1.41421	.44721
	highest	9	21.3333	1.73205	.57735

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means		Sig. (2-tailed)	Mean Diff	Std. Error Diff	95% Confidence Interval of the Difference	
		F	Sig.	t	df				Lower	Upper
score	Equal variances assumed	.354	.559	.923	17	.369	.6667	.72220	-.85704	2.19037
	Equal variances not assumed			.913	15.515	.375	.6667	.73030	-.88543	2.21877

Table 4

Correlations

	Ptstaff	Educatio	Experien	Agerange	Amount
Ptstaff Pearson Correlation	1	.003	-.046	-.066	-.339
Sig. (2-tailed)	.	.990	.852	.788	.156
N	19	19	19	19	19
Educatio Pearson Correlation	.003	1	-.458*	.248	.003
Sig. (2-tailed)	.990	.	.049	.305	.990
N	19	19	19	19	19
Experien Pearson Correlation	-.046	-.458*	1	.000	-.222
Sig. (2-tailed)	.852	.049	.	1.000	.360
N	19	19	19	19	19
Agerange Pearson Correlation	-.066	.248	.000	1	-.523*
Sig. (2-tailed)	.788	.305	1.000	.	.022
N	19	19	19	19	19
Amount Pearson Correlation	-.339	.003	-.222	-.523*	1
Sig. (2-tailed)	.156	.990	.360	.022	.
N	19	19	19	19	19

* Correlation is significant at the 0.05 level (2-tailed).

Table 5

Correlations

		Amount	Agerange	Educatio	Experien	Ptstaff	Score
Amount	Pearson Correlation	1	-.523*	.003	-.222	-.339	-.078
	Sig. (2-tailed)	.	.022	.990	.360	.156	.752
	N	19	19	19	19	19	19
Agerange	Pearson Correlation	-.523*	1	.248	.000	-.066	-.218
	Sig. (2-tailed)	.022	.	.305	1.000	.788	.369
	N	19	19	19	19	19	19
Educatio	Pearson Correlation	.003	.248	1	-.458*	.003	-.725**
	Sig. (2-tailed)	.990	.305	.	.049	.990	.000
	N	19	19	19	19	19	19
Experien	Pearson Correlation	-.222	.000	-.458*	1	-.046	.282
	Sig. (2-tailed)	.360	1.000	.049	.	.852	.243
	N	19	19	19	19	19	19
Ptstaff	Pearson Correlation	-.339	-.066	.003	-.046	1	.204
	Sig. (2-tailed)	.156	.788	.990	.852	.	.403
	N	19	19	19	19	19	19
Score	Pearson Correlation	-.078	-.218	-.725**	.282	.204	1
	Sig. (2-tailed)	.752	.369	.000	.243	.403	.
	N	19	19	19	19	19	19

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

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