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Designing a Better Day: Adult Day Centers: Comparative Case Studies

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ABSTRACT

The adult day center (ADC) is emerging as a new and important social institution and place type in the continuum of care environments. Nine case studies representing the range of ADCs currently operating in the United States are considered from a holistic, systemic perspective. Each case is presented in terms of place profile, program, physical setting and "the place in use." The results are not a matter of ADC "best practices" or "good/bad" ways of doing things, but rather a method of identifying characteristics and components that appear to contribute to making a positive difference in the experience of adult day care.

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- Jennifer Kingsbury, University of Wisconsin-Milwaukee
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- Yavuz Taneli, University of Wisconsin-Milwaukee School of Architecture and Urban Planning

This monograph is dedicated to all adult day care center participants and their family caregivers: We wish to express our deep admiration for their courage, dedication and the determination to make tomorrow a better day.

Introduction

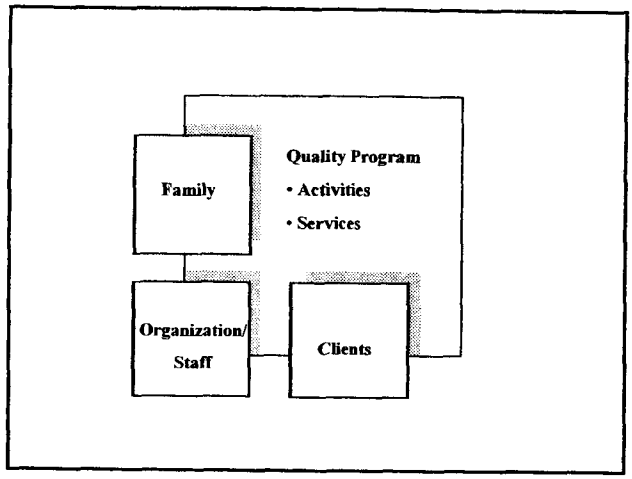
Adult day care is emerging as a new and important place type in the continuum of care environments for the elderly. The number of adult day care facilities is doubling roughly every 10 years (NIA, 1997), and a study by the National Adult Day Services Association (NADSA) indicates that most individuals currently served by adult day care would otherwise reside in institutional settings (1997). Compared to the social and economic costs of institutionalization and home health care, adult day care is an innovative alternative. However, as a new and unique social institution and place type, adult day care has yet to be effectively defined. As a result, adult day care centers are found in a variety of building types, ranging from new purpose-built facilities to remodeled residences, nursing homes and the proverbial church basement. Likewise, adult day cares in operation today vary widely in terms of their philosophy and orientation, case mix, funding mechanisms, and services provided.

Guidance for Planning and Design

This book has been written to serve the needs of people involved in developing adult day care centers: program administrators, care professionals, and environmental designers such as architects, landscape architects and interior designers. Because the place type of adult day care is relatively new, there is little guidance available for planning or design. The guidance that does exist tends to be limited to specific aspects of day care, for example, market analysis, financing, staffing, architectural design or operation. While useful, these topic-specific guides fail to recognize the reality that an adult day care center is a dynamic, reciprocal and interdependent **system**. Though the different aspects of an adult day care can and at times must be considered and treated independently, from a systems perspective an adult day care exists as a "place," a unified entity that is experienced holistically.

This holistic, systemic perspective gave rise to an approach to studying adult day care centers we describe as **The Place In Use**. The advantage of the The Place In Use approach is that it enables the simultaneous consideration of the diverse range of factors that influence a particular place, such as organizational mission, program of activities, characteristics of the physical environment and perhaps least explored but vitally important, the experience of being in that place. The results of The Place In Use approach are less a matter of adult day care "best practices," or even "good versus bad" ways of doing things, but rather a method of identifying characteristics and components that appear to contribute to making a positive difference in the experience of adult day care.

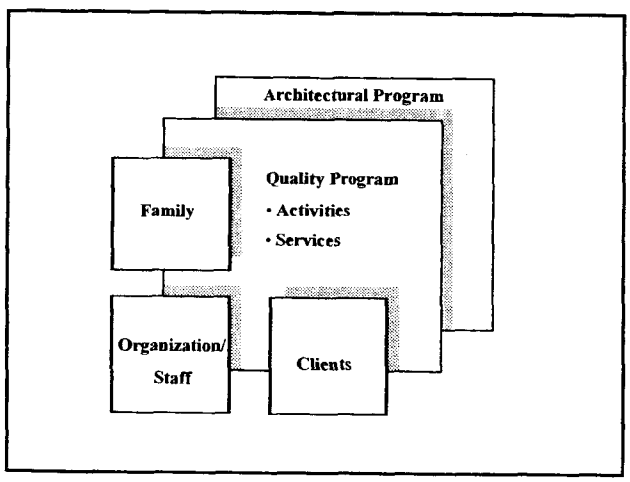
It Starts with the Program



The range of human resources that contribute to a quality program

Every conscientious adult day center begins with a quality ***program*** that combines a range of ***activities*** with responsive therapeutic ***services***. Providing an effective program requires the marshalling of a range of human resources. There must be a knowledgeable and committed staff, representing the goals and values of a supportive organization. Quality care relies on the active involvement of formal as well as informal caregivers, not just staff but also participants' families and friends. The real gauge of quality, however, is determined by the degree of "fit" between what a program offers, and the desires and capabilities of the clients that the program is designed to serve.

Of course, people and activities don't exist in a vacuum. People engage in activities within the context of ***the physical setting***. Although it is habitually overlooked, in reality the physical setting is a central component of every adult day care. The physical setting affects the program of activities and services offered, influences the behaviors and attitudes of caregivers, and most importantly, shapes the overall experiences of adult day care participants who are disadvantaged by their physical and cognitive impairments.

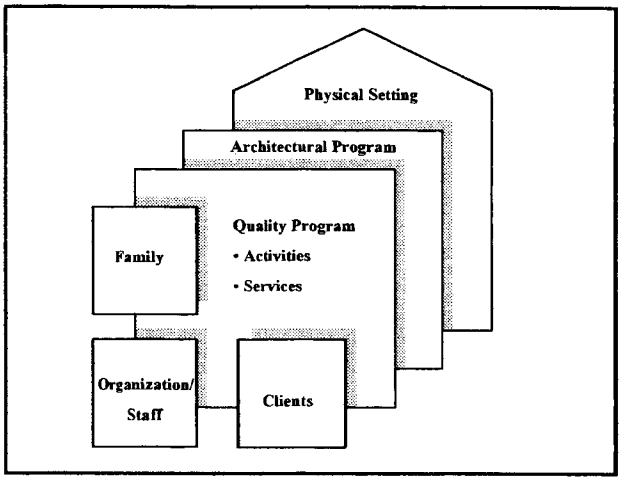


Linking who, when, what, and why to <u>where</u>

Because the physical setting plays such a central role, it is imperative that the spaces of adult and dementia day care centers be ***architecturally*** programmed with the same attention dedicated to programming the activities to be accommodated in those spaces. An architectural program, an important document used to help guide the process of architectural design decision-making, relates ***who*** will be doing ***what, when, why*** and ***with whom*** to ***where*** and ***how*** those activities will be taking place. At its best, an architectural program details not only the tangible characteristics of spaces--size, location, sensory properties, furnishings, level of finish and equipment--but builds upon the activities program to imagine and describe the ***experience*** envisioned for each space--in short, the architectural program should convey the intentions of the place in use.

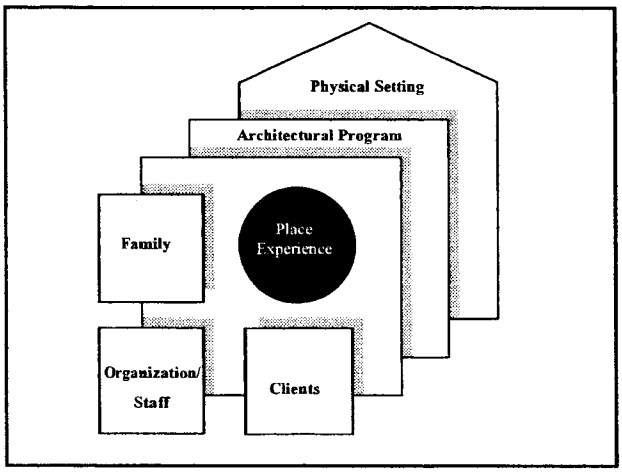
Place Experience: Linking Activities with the Physical Setting

The transitions from the adult day care activities program to the architectural program to the design challenge architects and clients alike. Simply knowing that a nurse's assistant will bathe five physically-impaired elderly people in a day tells us little about the nature of the adult day care bathing experience, or the space in which bathing will take place. How do clients react to the fact that they need assistance in this most private of activities? What do caregivers do to afford a client some degree of dignity? What techniques do caregivers use to ensure their own health and safety while bathing a day care participant? Even knowing that a counseling room will be 100 square feet with a desk, computer, and telephone jack offers little support for the myriad design decisions required by a relatively simple space. How can the complex, interpersonal world of human use and the physical world of bricks and mortar be connected?



Transition from activities program to architectural program, to designed environment

In our view, **place experience** is the link between people, activities and the physical setting. Theoretically speaking, place experience is defined as a contextually-specific form of comprehension that emerges from the interaction of people, program and physical setting. In less formal terms, the concept of place experience is the means for understanding what a place "feels like." Place experience can be described from your own point of view, or that of another person, group or groups of people. Though we can't presume ourselves able to truly comprehend the place experience of someone suffering from dementia, we can raise our awareness and enhance our understanding of how place experience is shaped by incorporating information from knowledgeable sources.



Place experience is the link between human resources, the program, and the physical setting.

Attributes of Place Experience	
Accessibility	Ease in physical locomotion through and use of a given environment
Activity	Perceived intensity of ongoing behavior within a given environment
Adaptability	Extent to which the environment and its components may be reorganized to accommodate new or different patterns of behavior
Comfort	Extent to which the environment provides sensory and anthropomorphic fit and facilities task performance
Control	Extent to which a given environment facilitates personalization and conveys territorial claims to space
Crowdedness	Perceived density level within a given environment
Legibility	Ease with which people can comprehend key elements and spatial relationships within an environment and effectively find their ways
Meaning	Extent to which a given environment has individual or cultural meaning(s)
Privacy	Ability to monitor the flow of visual and auditory information to and from others within the given environment
Security	Extent to which an individual feels physically and emotionally secure within a given environment
Sensory Stimulation	Quality and intensity of stimulation as experienced by the various sensory modes (seeing, hearing, smelling, tasting, feeling)
Sociality	Degree to which a given environment facilitates or inhibits social contact among people

We have found assessments from staff members responsible for the day-to-day care of participants an invaluable resource in our efforts to better understand the place experience of adult day care. Second, our reviews of the design for dementia literature suggest a dozen **attributes of place experience**, which have provided a useful inventory of fundamental person-environment qualities. A third source for increasing awareness of place experience is our own theoretically-informed observations of participant behavior in adult day care facilities.

We believe the concept of place experience affords us the best possible access to the perspectives of day care participants who are unable to articulate their own experiences. Place experience allows us to ask questions that have previously gone ignored or disregarded. For example, what aspects of an adult day care center are most obvious to participants? Are there features or characteristics that make the place seem more familiar or comfortable? How do participants feel about what they see, hear and do--is it too loud, not warm enough, or just right? Does the experience suggest the place is private or sociable? Tranquil or stimulating? What meanings do participants assign to the adult day care center and the activities within it? Does it feel like a social club, a neighbor's home, or a classroom?

Once we understand the answers to these questions, we can more readily "translate" the functional requirements of the care and activities program into the sensory and spatial properties of the architectural program. Walls must have a specific sound attenuation value to ensure privacy; seating arranged at right angles is more congenial and less confrontational than sitting across a table. The use of color and personal artifacts will help participants feel at ease. Architectural elements are then specified to provide a basis for the design of the physical setting.

To summarize, meeting our overall goal of "designing a better day" requires that we understand and accommodate ***all*** of the dimensions and factors that influence adult day care centers. As we have demonstrated, these dimensions include organization, families, participants and the physical setting.

A place for adult day care is the product of the transaction between people--those who are responsible for, engage in and experience the activities that happen there--and the physical setting--comprised of the physical elements that afford desired sensory and spatial properties. Experience, and more specifically, place experience, is what links human activities with the physical setting. Together, the three elements of activities, the physical setting and people's experiences combine to generate the "personality" of the place (Moos 1974, 1975). Only by dealing with adult and dementia day care holistically, that is in terms of its personality, purposes, program, setting and the positive experiences that are our goal--can we hope to succeed in "designing a better day" for those in our care.

Case Studies

As we have suggested, adult day care centers are complex systems comprised of interrelated social, organizational, psychological and architectural dimensions. There are financial and regulatory realities that must be accommodated, an organizational structure to be designed, and policies to be developed. In addition, there must be recognition that staff, clients and families are equally important players in the everyday reality of the place, and that all these elements converge to shape people's experiences of a given adult day center.

Given these complexities, how can we gain a critical understanding of adult day care as a place type? One method that has proven particularly useful in research on places is **case study analysis**. A case represents a single situation, but is organized in such a way as to highlight the many parts that form the whole. These parts may be defined in terms of dimensions (for example, organizational, social, psychological and physical), phenomena (everyday practices or "the way things are done around here"), time periods (for example, workdays, seasons or history) or place experience. Regardless of how they are structured, case studies achieve their power from their ability to "retain the holistic and meaningful characteristics of real life events" (Yin, 1989: 14). It is common practice to approach case writing in a way that lets the case "tell its own story" (Carter, 1993).

Case study inquiry happens most often on an informal basis when professionals visit comparable facilities. These site visits, while perhaps not systematic, typically yield useful information and shed light on organizations in operation and their decision-making processes. Most importantly, case studies allow professionals to learn by example.

Trade journals such as *Provider* and *Nursing Home* often include case studies as a way of helping administrators and care providers

enhance their practical understanding of the ways in which the organizational, architectural and experiential dimensions of places interact. Publications specific to adult day care such as the National Adult Day Services Association newsletter *Voice*, and the Bowman Gray School of Medicine's *Respite Report* likewise employ a case study approach.

Each Case Tells a Story

The case studies presented in this publication are designed to "tell the stories" of nine adult day care centers. As a set, these nine centers reflect the range of adult day cares currently in operation in the United States. Adult day cares are found in urban and rural settings. Their programs are housed in church basements and purpose-built facilities. Some offer no medical services; others are medically intensive. Since adult day care facilities vary considerably, rather than taking a line-item approach to underscore the differences between cases, we have endeavored to offer a sense of the unique "personality" of each adult day care.

As noted, the sample of cases included in this research effort has been selected to reflect the range of adult day care centers that exist in the U.S. The initial pool of potential case study sites was generated through a process known as snowball sampling. In this instance, sampling was generated by recommendations obtained from a panel of expert advisors assembled to provide guidance for the project as a whole. Individual adult day cares were selected on the basis of a number of criteria including reputation, convenience and researcher access as well as diversity along several dimensions including site context (rural to urban), operational orientation (i.e., organizational philosophy and care model) and building type.

A snowball sample is an example of non-probability sampling, where the selection of units is based on factors other than random chance. Thus, the sample of cases included here is neither exhaustive nor representative in a statistical sense. However, because the nine cases were selected to represent the range and variety of adult day care centers, our sample is consistent with the strategy known as heterogeneity sampling, or sampling for diversity. Each case represents a distinctive mixture of strengths and weaknesses, and a unique set of constraints and resources. Each case, therefore, yields a rich assortment of intriguing ideas and solutions, and as a result, each adult day care has a different personality. The cases presented here have not been chosen on the

basis of "goodness" or "correctness" in terms of how adult day care is provided, but rather for the conceptual density (that is, the number of concepts presented in a given amount of space) they provide collectively.

Case Methodology

Each case study has been constructed using data collected by means of four research methods: archival data; surveys; interviews; and observations. Archival sources included architectural plans as well as background information such as mission statements, activities programs and participant profiles. Concurrent with the gathering of archival material, each program administrator was asked to complete a survey addressing specific organizational and programmatic issues. Together, these items provided the research team with a contextual "snapshot" of each adult day care. This material was analyzed by researchers to gain an initial understanding of the intentions and design of each adult day care center, and to identify specific topics for further inquiry.

4 Data Gathering Methods

- Archival
- Survey
- Interview
- Observation

Archival data and surveys provided the groundwork for subsequent field studies conducted at each adult day care. Over a period ranging from five hours to one and a half days, data in the form of field notes and interpretive journal entries were recorded during site visits as the researchers experienced each place. Records of the behavior of staff and participants in terms of their movements within the day care areas were made directly onto floor plan "maps" of the spaces. The research team then reviewed their field notes, interpretive journal observations and behavioral maps in discussion sessions to arrive at a shared understanding of each place. In these sessions, additional questions emerged to be addressed in the return site visit, which included a semi-structured, in-depth interview with the administrator. These return visits allowed researchers to verify their impressions and understanding of each place. To ensure consistency and accuracy of interpretive understanding of each adult day care, the process was intentionally progressive and dialogical.

The Structure of the Cases

Each case study begins with a broad **Theme** that conveys the essence of the case, followed by a **Place Profile**, which provides a concise introduction to the adult day care. The descriptive portion of the case study is covered in two sections: the **Program**, which includes mission, goals, services and activities, and participant profile; and the **Physical Setting**. Excerpts from the semi-structured interviews are used to highlight specific points covered in the descriptive section of each case study.

Case Outline

- Theme
- Place Profile
- Program
- Physical Setting
- The Place In Use

Questions posed by researchers are designated as "Institute" and responses offered by day care administrators as "ADC." In cases where more than one administrator was involved in the interview, they are referred to as "ADC 1" and "ADC 2." While every effort has been made to retain the meaning and intent of statements made during interviews, the research team has reserved the right to make editorial revisions to content for the sake of clarity.

Perhaps the most important section in each case study comes under the heading **The Place In Use**. **The Place In Use** tells the story of "a day in the life" of each adult day care: the activities in which people engage, the properties and features of the physical setting seen as supportive of those activities, and the experiences of the people who spend their days there. Together, activities, the physical setting, and people's experiences generate the unique personality of each adult day care.

Realms of Activities/Experience

The framework by which **The Place In Use** section is organized is an outcome of the process of case analysis. Through analysis, several patterns of activities emerged as common across day care facilities and central to the adult day care experience. These recurring patterns are termed **Realms of Activities/Experience** to reflect the fundamental connection between activities (shared behaviors that occur in the social realm) and experience (perceived by the individual as internal and psychological) that coincide with a particular day care space or area within a space. There are eight Realms of Activities/Experience:

- Coming and Going
- Primary Program Spaces
- Kitchen and Kitchen Work
- Dining
- Personal Care: Toileting
- Personal Care: Bathing
- Wandering and Elopement
- Outdoor Space

Each Realm is introduced by narrative text that describes the activities/experiences in conjunction with the corresponding physical environment. The narrative description is also supplemented by excerpts from interviews to provide a richer illustration of the context and related issues. Since not every Realm is relevant to every adult day care in the sample, each case study addresses only those applicable Realms.

The Adult Day Care Cases

The nine case studies that appear in this publication focus on the following adult day care centers:

- Alzheimer's Family Care Center, Chicago IL
- The Caring Place, Waukesha WI
- Catholic Charities Adult Day Services and Resource Center, Milwaukee WI
- Elder Care of Dane County, Madison WI
- Louis Feinstein Alzheimer's Center, Cranston RI
- Kiel Adult Day Services Center, Kiel WI
- Luther Manor Adult Day Care Center, Milwaukee WI
- St. Ann Center for Intergenerational Care, St. Francis WI
- Shepherd House, Milwaukee WI

Each is a unique example of adult day care; each represents a different vision of what an adult day care is as a place. The following matrix offers a comparative summary of the context and qualities of the nine adult day cares, as a foundation for the in-depth account of each case that follows.

The Better Day Design Series

This monograph is the second in a series of three dedicated to the topic of adult day care facilities. The first volume is an annotated bibliography of research and professional literature related to adult and dementia day care. The third volume will consist of planning and design guidelines intended to assist program administrators, care professionals, and environmental designers including architects, landscape architects and interior designers through the complex process of adult day care facility development.

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Comparison Matrix

Facility/case study name	Kiel	Caring Place	Elder Care	Feinstein
Building type	Former Private Residence	Remodeled Church Basement	Remodeled Commercial	Purpose Built
Context: Small Town (1) - Big City (5)	1	2	3	3
Square footage, total	1,700	2,722	9,500	6,500
Cost, total (estimated)	NA	$215,000	$142,500	NA
Cost/square foot (estimated)	NA	$79	$15	NA
Year facility opened	1994	1988	1997	1995
Enrolled clients, total number	11	55	96	85
Client capacity	15	22	78	50
Daily census, average	6	20	52	45
Age range	57 to 88 years	68 to 95 years	55+ years	56+ years
Age average	79	83	73	82
Client gender ratio, male: female	1:3	1:4	1:8	1:2
Cognitively impaired clients %	100%	50%	41%	100%
Incontinent clients %	0%	30%	24%	59%
Wheelchairs, % clients using	10%	10%	31%	16%
ADLs/client, average	1	2 to 3	3	42% 3+
Client toilet fixtures, number of	1	5	7	5
Bathing tubs, number of	0	1	0	0
Showers, number of	0	0	3	2
Client bathed daily, number of	0	5	16	3 to 4
Outdoor space, square footage	Adjacent to city park	0	600 sq. ft.	Adjacent to city park
For profit or not for profit	NP	NP	NP	NP
Daily charges	$5 to $35	$26 to $36	PACE	$35 to $56
ADC staff	2	8	11	21
FTE staff	0.75	7	11	16.5
Care staff/clients average daily ratio	1:2 to 1:4	1:4	1:5	1:3.5
Client ethnic background by %	100% Caucasian	100% Caucasian	61% Caucasian 32% African American 5% Hispanic 2% Hmong	92% Caucasian 5% Hispanic 3% African American

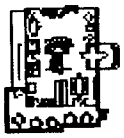
Luther Manor	Catholic Charities	Shepherd House	St. Ann Intergenerational	AFCC
Purpose Built	Purpose Built	Remodeled Convent Basement	Purpose Built	Remodeled Industrial
3	4	4	4	5
10,500	6,000	6,300	43,000/ADC 6,500	11,500/ADC 9,000
NA	$630,000	NA	$5,079,000	$600,000
NA	$105	NA	$118	$67
1990	1997	1983	1997	1995
172	80	90	107	94
55	50	50	60	75
48	45	48	41	55
53 to 96 years	50+ years	60+ years	18+[1] years	38 to 97 years
83	82	77	78	80
1:2	2:3	1:3	1:2	1:2
90%	60%	100%	60%	100%
50%	40%	74%	75%	60%
35%	10%	31%	75%	8%
57% 3+	1 to 2	2	2	NA
6	6	5	5	9
2	1	2	4	0
0	1	0	8[2]	2
12	3 to 4	12 to15	13	0
500 sq. ft.	3/4 acre	0	4,550 sq. ft.	1,000 sq. ft.
NP	NP	NP	NP	NP
$45	$34	$43	$43	$45
17	13	28	18	17
17	6	21	17	17
1:6 to 1:10	1:4 to 1:8	1:4	1:6	1:3
70% Caucasian 30% African American	60% Caucasian 39% African American 1% Asian American	96% Caucasian 3% African American 1% Hispanic	96% Caucasian 3% African American 1% Hispanic	75% Caucasian 14% African American 11% Other

1 Includes developmentally disabled young adult program.
2 Includes showers in pool area.

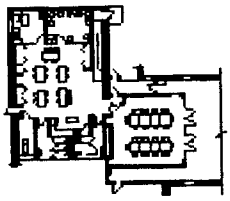
Comparitive Floor Plans

A comparison of relative sizes of the nine adult day care facilities examined in this study.

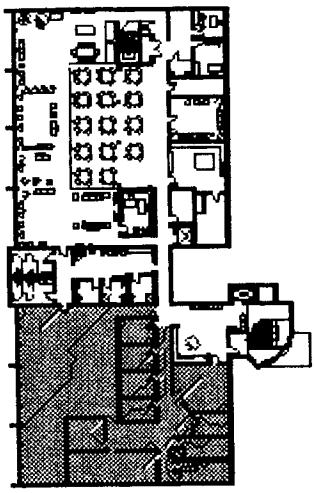
Program space
Non-program space



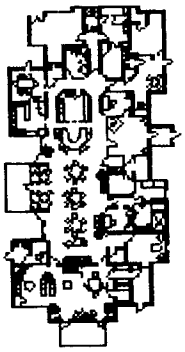
Kiel Adult Day Services Center



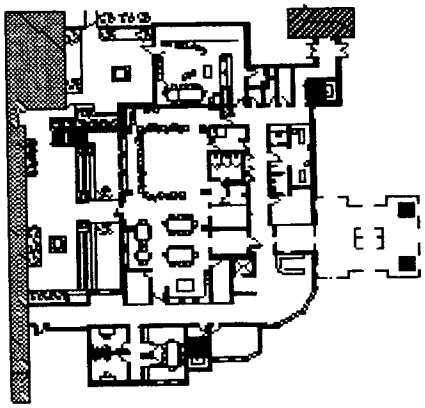
The Caring Place



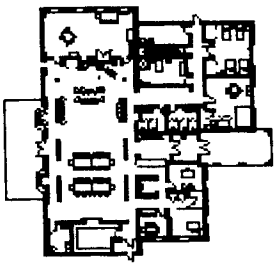
Elder Care of Dane County



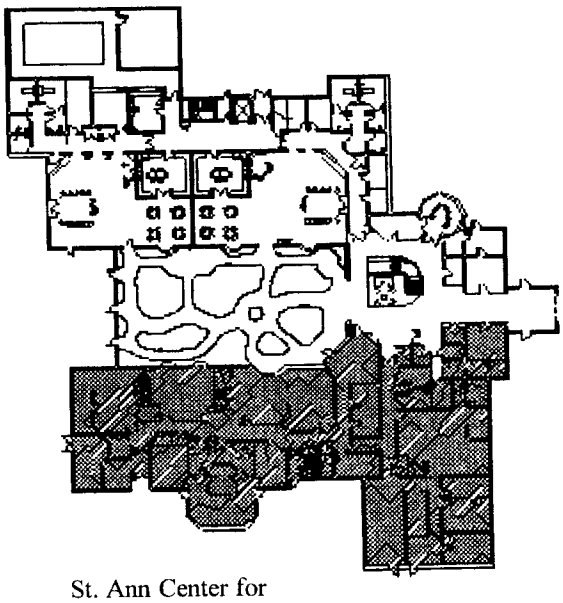
Feinstein Alzheimer's Care Center



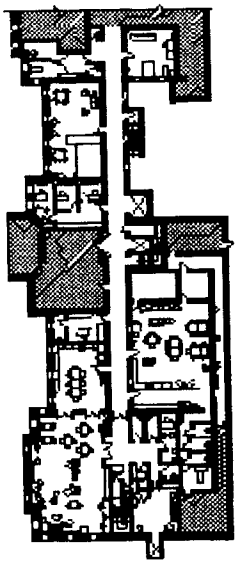
Luther Manor Adult Day Care Center



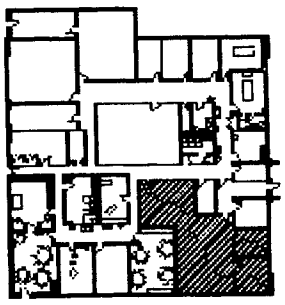
Catholic Charities Adult Day Services and Resource Center



St. Ann Center for Intergenerational Care



Shepherd House



Alzheimer's Family Care Center

Kiel Adult Day Center
Kiel, WI

Theme
Welcome to our home.

What this case study shows:
- The challenges associated with integration and adaptation of a community landmark for use in adult day care.
- The benefits of small scale for a dementia population.
- The benefits and drawbacks of having a high level of personal involvement from the board of directors.

Place Profile

Directors
Dorrae Fietz, Adult Day Service Coordinator, Family Services Lakeshore
Diane Grube, Director of Services, Kiel Adult Day Center

Site/context
Located off Main Street in rural Kiel, WI (population: 2,900)

Facility type
Former family residence

Building size
Approximately 1,700 square feet

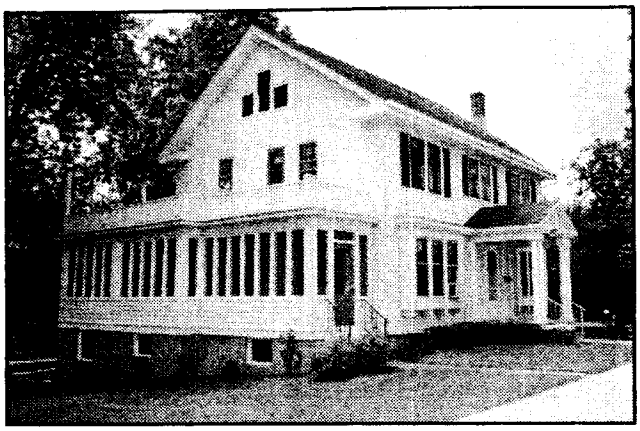
Construction completed
1922

Architect/designer
NA

Program

Mission and goals

Since 1991, Family Services Lakeshore has offered programs for elderly who are frail or suffer from confusion or memory loss. At sites in Kiel, WI and Manitowoc, WI, these programs allow families to keep their loved ones at home in familiar surroundings for as long as is reasonable. According to Dorrae Fietz, Adult Day Service Coordinator of Family Services Lakeshore, the goal of Kiel Adult Day Center is to provide respite for primary caregivers.



The three-season porch overlooks a park.

General description

Kiel Adult Day Center, which began operations in 1994, operates in a residence formerly owned by a prominent Kiel family, the Stoeltings. In the mid-1980s, the home was donated to the City of Kiel, which used it initially to house a community center. In 1996, the community center moved into a new purpose-built facility next door. At that time, the city agreed to lease the home at no charge to Family Service Lakeshore for the purpose of providing adult day care services. Overseeing the center is a nine-member board of directors, which includes the mayor of Kiel and two members of the Stoelting family who are now in their 80s.

ADC 1 *Even though they've given (Stoelting House) to the city and the city owns it, the board really reviews everything that happens to it. When we bought the two recliners, we had three members of the board come with us. They had to approve the furniture. So the two chairs that are here were not our original choice, but these were the ones that met their approval.*

Institute *So essentially every single detail is overseen, and the board and the Stoeltings are extremely involved in all the decisions.*

ADC 1 *Right. But they really let us do our own thing. If a coffee cup is broken they do want to have it left there so they are aware of it. It isn't a big deal.*

ADC 2 *Or moving the furniture in the living room. I called one day and said it really would be nice to have that piano on the outside wall so we could get into a better social circle. I called and they said that's okay, go ahead and move it.*

Because the home is owned by the city of Kiel, Stoelting House is occasionally used during off-hours for community events. In addition, rooms on the home's second floor are let out to civic organizations for storage.

Institute *You mentioned that Stoelting House is occasionally used for weddings and receptions and the like. Do you think that has repercussions for the adult day program?*

ADC 2 *Possibly.*

ADC 1 *Everything so far is being done at night or weekends...*

ADC 2 *They appreciate us in the building from what they've said to me...*

ADC 1 *...because we're a program that's there all the time, and Diane brings it to their attention when things are not being kept up. When there was a problem with the floor she was the one bringing it to their attention. And so they really feel she's looking after their building for them. So, I really don't think that our status would be threatened that much, because, again, we're not just a party, we're a community service also.*

Institute *Do you ever have any activities that carry over from one day to the next, with materials or things that you might want to leave out? How do you handle that?*

ADC 2 *We don't leave it out; it goes upstairs.*

Institute *Do you find that a disadvantage or just something that you work with?*

ADC 2 *We work with it.*

Institute *So it's not very bothersome?*

ADC 2 *No. We've been able to keep more things out more and more. We couldn't keep anything in the dining room buffet for two years, and then finally I just said this is what we have to do, we have to run this up and down the steps, and they said okay.*

ADC 1 *Originally we couldn't keep files; we couldn't keep anything here. So, I was taking a case back with me with every day. I brought the whole program with me every time I came. Really that's how we started.*

ADC 2 *As long as we put everything back and it looks neat, they're happy.*

Kiel Adult Day Center operates from 10:00 a.m. to 2:00 p.m. on Wednesdays, Thursdays and Fridays only. Plans to expand operation to additional days are currently under discussion. In general, each day's program provides opportunities for social interaction, a morning snack and hot lunch, cognitive activities, a gross motor exercise session and a relaxation period. Fees are charged on a sliding scale according to each participant's ability to pay. The maximum daily charge is $35; the minimum is $5.

Staffing

Kiel Adult Day Center has a professional staff of two; one is .75 FTE. In addition, the center relies heavily on a well-run volunteer system that provides a minimum of one or two volunteers each day. Volunteers include members of the center's board of directors as well as the community. Paid staff to participant ratio is 1:4; with volunteers, the staff to participant ratio is 1:2.

Participant profile

Kiel Adult Day Center has 11 enrolled participants, a maximum capacity of 15 and an average daily census of six. Its participants range in age from 57 to 88 with an average age of 79. All of its participants are Caucasian. The female/male participant ratio is 3:1. All participants have some degree of cognitive impairment, and require assistance with an average of one ADL. Ten percent of participants use wheelchairs. At this time, no participants are incontinent.

Institute *If the needs of a member changed, exceeding the ability of the program, what would happen? Would they go to another adult day care program in the area? Have you had someone become, say, incontinent, or develop other medical or physical needs that you are not equipped to deal with?*

ADC 1 *Well, with incontinence, as long as they are cooperative in allowing us to assist them in changing and they cooperate in wearing some type of incontinence undergarment, then it isn't a problem. But if their needs are safety issues like falling--if they wouldn't allow us to have a gait belt and walk with them and things like that, then we would have to have some type of a meeting with the caregiver and/or social worker.*

ADC 2 *Or if they become combative.*

ADC 1 *Right. We try to keep people in our program as long as the family can have them at home.*

ADC 1 *In the case of increased needs, do they become apparent from the family's perspective as well as yours?*

ADC 2 *We seem to see it sooner. Families don't want to recognize it...because they know what the next step has to be.*

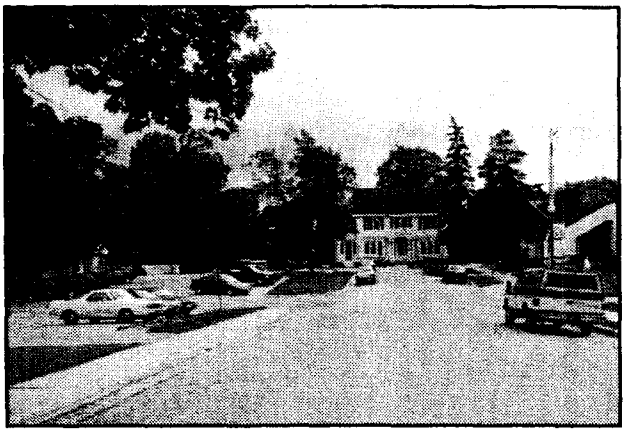
Institute *What kind of communication goes on between you and the family? Daily or monthly reviews?*

ADC 2 *It's so individualized. I think with some it's on a daily basis, and with others not. We have some members who have professional caregivers, or a family out of town: then there isn't that much exchange of information. But even for those with families out-of-state, we send at least a six-month update. If there's a social worker, they get a three-month written update.*

ADC 1 *If the physical needs couldn't be met here at this program, we would have the option of sending them to Manitowoc, transporting them by Handicare (a transportation service) or something if all involved were agreeable. It has never happened. The people who have left our program have gone directly into a nursing home because the family couldn't cope with the needs.*

Physical Setting

Kiel Adult Day Center operates in a former private residence that is located on a cul de sac off Main Street, flanked by the city library and community center. Behind the house is a one-acre natural pond encircled by a paved walking path and surrounded by park benches and tall mature trees. A bridge over the pond provides access to the adjacent community park and cemetery.



The surrounding neighborhood.

Stoelting House is a two-story center entrance Colonial, built in 1922. The exterior is wood siding, painted white. The center entrance features a porch supported by pairs of wood columns. Three concrete steps lead to the front door; handrails are wrought iron. Traditional black shutters trim the windows.

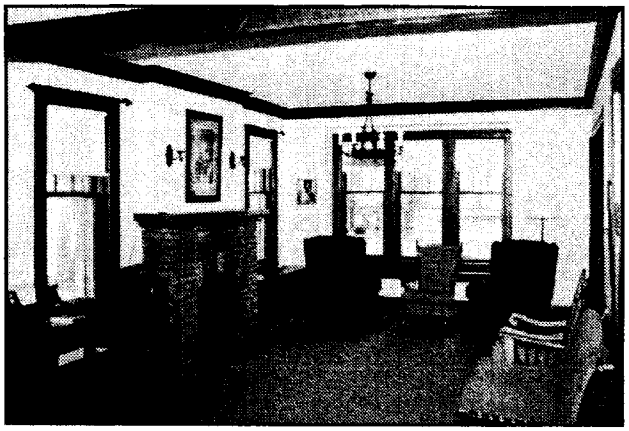
All primary program spaces for Kiel Adult Day Center are located on the first floor of the house. These spaces consist of the living room, the dining room, the kitchen, and the three-season porch. There is one bathroom on the first floor, which contains a residential toilet and sink.

A bridge leading to the community park.

Barring a mobility impairment, entrance to the program is up the three steps and through the aluminum storm door and original paneled wood interior door. Those in wheelchairs or for whom the steps are not manageable must use the exterior ramp located at the rear of the building. This ramp opens onto the screen porch; access is through the kitchen door.

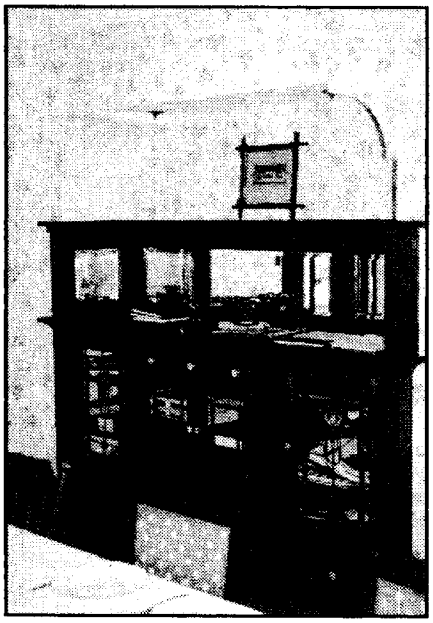
From the front door one arrives in a small enclosed vestibule; along one wall is an exposed hanging rod with hangers labeled with each participant's name. A second solid wood door opens into the central entry hall. The entry hall features the original oak stairway and balustrade, muted contemporary wallpaper and a residential telephone on a wooden stand.

To the right of the entry hall is the living room, a generous (23' x 14') room created by the removal of the original partition wall between two parlors. The living room has a working fireplace, dark-stained oak trim and a wood window seat. Walls are painted off-white. Windows on three sides of the room admit plenty of natural light, which is supplemented by incandescent lighting from the house's original fixtures and floor lamps. A large picture window provides a view of the pond.



The living room.

Vinyl roller shades are the sole window treatment. Flooring is industrial-style tight loop carpeting that is light brown in color. Vintage recliners and Early American style chairs and a sofa with wood arms and upholstered seats and backs line the perimeter of the room. A television and upright piano are used for entertainment. Accessories include framed prints, silk plants and flower arrangements, and an American flag.



Oak buffet in the dining room.

To the left of the entry hall is the dining room. It features a residential double-pedestal dining table that seats ten. As luck would have it, wheelchairs fit easily under the table. Dining chairs are all wood or wood and upholstery. Flooring is light stained oak, and walls are papered in a muted floral pattern of cream, pink and green. In the window bay is a wooden window seat. Mounted in the bay is a room air conditioning unit that cools the entire first floor. A built-in buffet of oak, mirrors and stained glass sits in an arched alcove; the buffet is used for storing activity items and to display a vintage glass compote set.

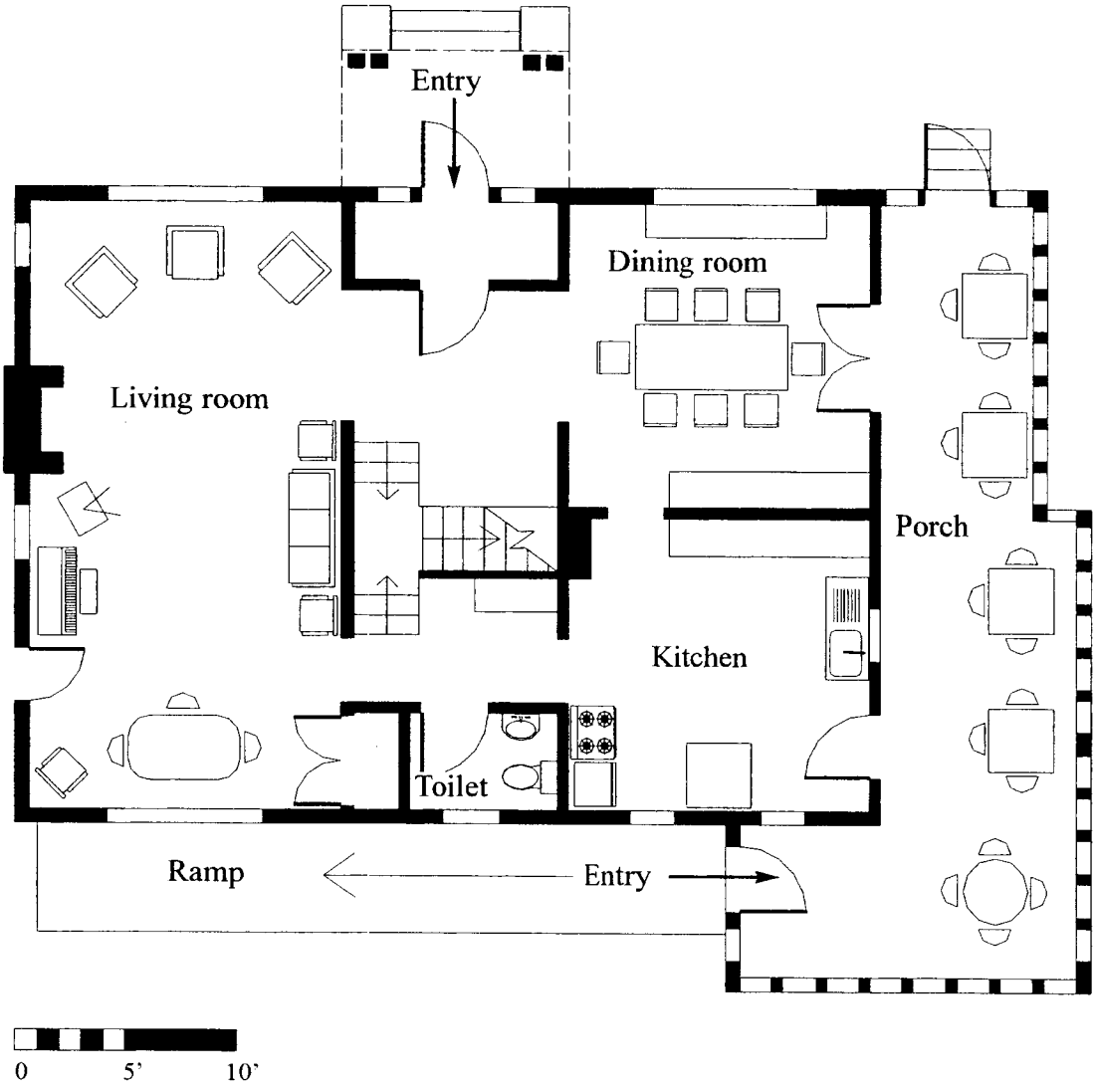
The three-season porch is accessed from the dining room through French doors. The porch has windows on three sides as well as a street-side exterior door. Flooring is indoor-outdoor carpeting in a pink tone, and the ceiling is light stained wood bead board. The room is furnished with folding card tables and chairs of metal and vinyl, and stackable white resin chairs.

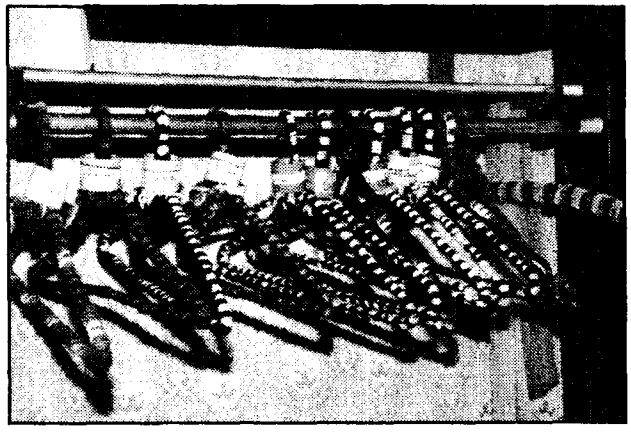
The home's original kitchen is intact and used daily for preparing coffee and snacks as well as plating the hot lunch that is delivered in bulk by arrangement with the adjacent community center. Walls are painted white. Flooring is vinyl. The one incandescent ceiling fixture leaves the space somewhat underlit. Appliances include a residential refrigerator, range and microwave.

In the kitchen, the shallow cast iron and porcelain sink with integral drainboard is vintage. Wood cabinets painted white are primarily solid-fronted, although three are glass. Most food preparation is done on the kitchen worktable, which is covered by a vinyl tablecloth; other counter space is negligible. The room has two windows and one door that leads to the three-season porch.

One of the second-story bedrooms houses the office of the center's director; others are used for storage for the day care as well as for unrelated civic organizations.

Floor Plan: Kiel





Personalized hangers.

Coming and going

Kiel Adult Day Center operates on Wednesdays, Thursdays and Fridays from 10 a.m. until 2 p.m. The director is on site those days from 9 a.m. until 5 p.m. Generally, participants arrive slightly before 10 a.m., although it is not uncommon to have one or two arrive as early as 9:15. Participants are transported individually by family member or community services station wagon. One participant is transported by a volunteer from her church.

Except for the one participant who is in a wheelchair, all others successfully manage the front steps into the center with some assistance. Outerwear is removed in the foyer and stored in the vestibule on decorated and personalized hangers. Purses and other personal items are stored in a closet located in a corner of the living room.

ADC 1 *We open at 10:00, and today members started coming at 9:30. With as many volunteer drivers as we have, we need to have some flexibility.*

Institute *Is that a challenge for you when you're planning for 10:00? Say three people are dropped off between 9:15 and 9:30, what would happen? Do you have an activity for them?*

ADC 2 *Usually it's a social time for them. They go to the bathroom, put their purses away, and then they kind of mingle with each other and talk to each other. Then another group comes in.*

ADC 1 *Then that's a whole new social time.*

ADC 2 *Right. They all really care about each other: they're friends.*

Departure is an equally calm transition. All departures occur within a 15-minute time period. The last activity of the day occurs in the living room, and participants are summoned individually as a family member or driver arrives to take them home. A relaxed discussion of the day's last activity provides low-level distraction, and little agitation or anxiety in remaining participants was observed.

Institute *So around 2:00 residents are getting ready to leave. How does that work? Usually they're in the living room?*

ADC 2 *Yes. The driver will pick up two or three at a time so there isn't this big rush. They*

usually take home city people first, and then they come back for the ones who live further out.

Institute *Is there usually one driver that takes people home and picks them up?*

ADC 2 *Pick up and drop off is the same driver, but each day is a different person.*

Institute *When they're waiting to go home, do members ever get antsy or agitated? Does it seem to bother the ones who are last to go?*

ADC 1 *Occasionally you'll have some that, with some people....*

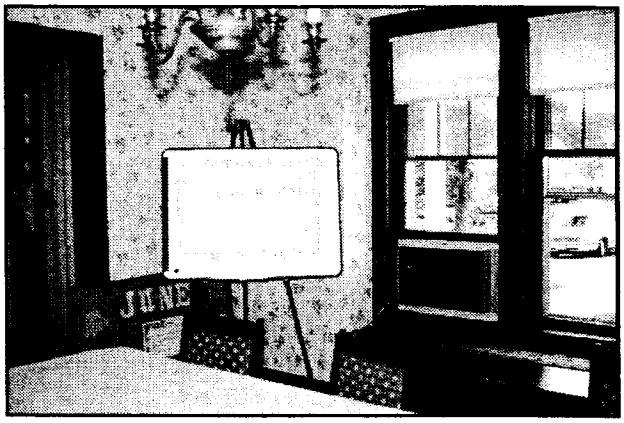
ADC 2 *It's more of a problem if they see the other people going, but if they don't see them leave it's not an issue.*

Institute *Do you actively engage them in activity right around departure time?*

ADC 1 *Yes. I've also noticed if the members' name tags are coming off, it seems like a signal that it's time to go...so we keep name tags on.*

Primary program spaces

Programmed activity at Kiel begins with coffee and a morning snack, which is taken in the dining room. The snack is followed by a cognitive activity also conducted around the dining room table. The group then moves into the living room for a physical exercise session, at which point the dining room is prepared for lunch. After lunch, the group returns to the living room to engage in a cognitive activity game or to watch a video that has been borrowed from the library located next door to the center.



Cognitive activities in the dining room.

Special events and outings are conducted throughout the year. Holiday performances or children's art shows are staged at the Kiel Community Center; participants often receive formal invitations to these events and the excursion is much anticipated. Support of the center by community members is evident through the sponsorship of walking trips to local shops.

Institute *Given your population, do you schedule certain activities depending on who is coming that day?*

ADC 2 *Yes and no. We do try to meet their skill levels. Like with card games, for example, we have some who can play Sheepshead and some who can't play Fish. We try to*

balance it--find an activity that all levels can do or find a volunteer to go with one group and a staff person with the other group.

ADC 1 *We don't have cards every day. We play bingo every day.*

ADC 2 *Some of them are invited over to the community center to play cards with their friends from the old neighborhood.*

Institute *So some people, even while they're under your care for the day, can and do engage in activities as they used to do.*

ADC 2 *We do lots of "regular" activities. We go to the park. We feed the fish, feed the birds. We save our leftover bread...it all depends on the weather. We're planning to walk over to Dairy Queen (across the street). Quik Trip gave us a tour of the back of the building, inside where they have their freezer section. We walked up to the jewelry store. They asked us to stop in and visit.*

Institute *What about providing quiet times? Is there any place someone can go if they want to be alone for a couple of minutes?*

ADC 1 *We have one woman, for health reasons and her age (she's in her late 80s), will go sit in the other room and put her feet up.*

Institute *But generally you don't have other people who need to take naps?*

ADC 2 *No.*

ADC 1 *It's only four hours, so by the time you get social time, have a snack, do some activities, then it's lunch time. After lunch those who want to can put their feet up, while others are helping with wiping the table or sweeping. After that it's on to more activities. It's really a short period of time, it goes very quickly.*

ADC 2 *Yeah, they complain sometimes about that.*

Institute *About the short time period?*

ADC 2 *Yes.*

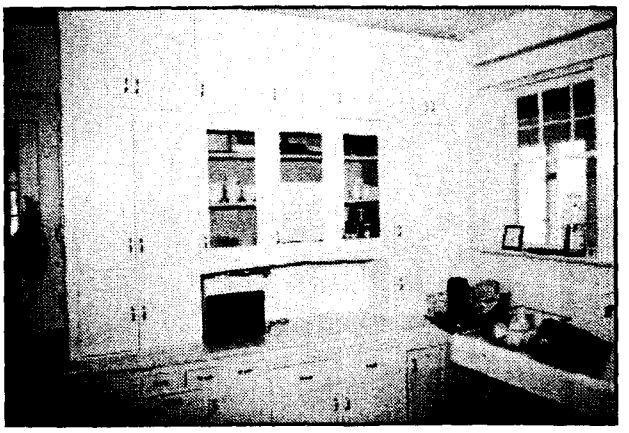
Institute *It seems activity-packed.*

ADC 2 *They sleep better at night.*

Kitchen and kitchen work

The kitchen at Stoelting House is original to the 1922 vintage house. Copious cabinet space and broom closets provide storage for dinnerware and cleaning implements as well as a variety of activity props. Glass-fronted cabinets provide visibility for stored items.

While participants are allowed to use the space, the room's size, awkward positioning of the appliances (jutting into the room), and lack of seating preclude most kitchen activity. As a result, the kitchen space is used most as a walkway to the toilet room.



Built-in cabinets in the kitchen.

Institute *It's a nice touch to use the coffee cups and china that's here. Really homey. Do you do any activities in the kitchen: cooking, baking?*

ADC 2 *Applesauce.*

ADC 1 *You went to the orchard.*

ADC 2 *We went to the orchard, they picked the apples and brought them back and made applesauce. That was a three-day process...*

ADC 1 *Eating was on day three!*

Institute *Do people wash dishes? Do they clean up?*

ADC 2 *They'll clear the table, but because of state rules we have to be real cautious. They'd like to dry dishes, but they can't because we have to air dry them and then there's bleach out. You give some of them a wash cloth, and they'll wipe the table. They can do things like that. Or they'll wipe the stove off, clean the refrigerator or sweep.*

Institute *So you try to find an ancillary activity that doesn't interfere with regulations?*

ADC 2 *Right. They'll fold the dishcloths.*

The dining room set for lunch.

Dining

Dining at Kiel consists of the morning coffee session and hot noon meal. By contract, lunch is delivered in bulk from the Kiel Community Center next door and individually plated by day care volunteers as well as passed family style when appropriate. Lunch is served on plates at the dining room table, with cloth napkins and metal utensils for each participant. No participant requires assistance with eating. Staff and volunteers eat lunch with participants at the dining room table.

ADC 2 *We've always done just regular family style.*

ADC 1 *Unless they have a special diet that would need to be brought in and portioned. Other than that it's family style. Family, staff, everybody eats together, like the Waltons', you know, everybody at the big table. People who need assistance with cutting and that type of thing...it's really easy.*

ADC 2 *We've had the reverend come and volunteer, and he gets candles out every once in awhile. He comes and sets the table and lights the candles. It's very relaxing.*

Institute *So the table is set. Do you bring the food out and put it on each plate, or do the members sit down and serve themselves?*

ADC 2 *It depends on their needs. Usually the food is brought out, they sit down, and we help with serving the food. They don't always remember to pass the serving dish on to the next person.*

Institute *So you initiate, they serve themselves and pass it to the next person.*

ADC 2 *Yes. We do like them to stay as independent as possible.*

Institute *How many people typically need assistance?*

ADC 2 *Oh gosh, assistance with just cutting or buttering bread--two of eight.*

ADC 1 *And I know that according to the national ADL standards, if they can use an instrument to get food to the mouth then they can feed themselves. By those standards, all of our members are independent and able to feed themselves.*

Institute *You talked about special diets. How many people have special diets?*

ADC 2 *We have two diabetics. Really the big difference is in their Jell-O, their salad and dessert. The main course is the same.*

ADC 1 *And in the morning when everyone's having coffee time with cookies. There were no diabetics today, but if there were they would have been having something a little bit different than the regular snack. It's not meant as a nutritional snack, it's just a social snack.*

Institute *What sorts of foods are on the menu?*

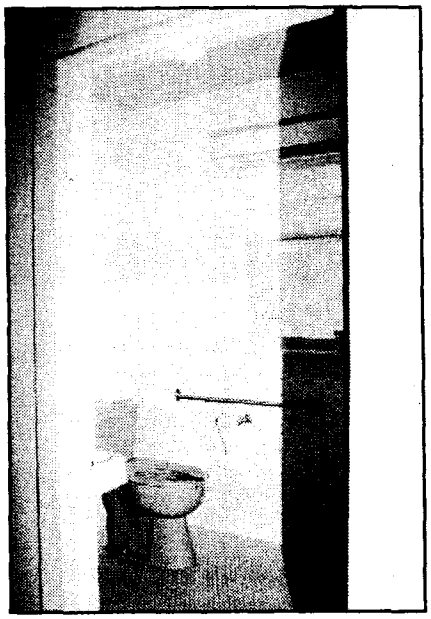
ADC 2 *Yesterday we had baked chicken and baked potato.*

ADC 1 *We have salmon loaf, lasagna.*

ADC 2 *Salmon loaf last week, and today we might have chili. Just regular old-fashioned cooking is what it really is. In summer they (the community center food service) focus more on the senior center because they don't have to cook for the schools. Through the school year there's a difference in menus, because the kids like pizza burger or chicken nuggets. We don't necessarily get that. They still pretty much serve what's better and more familiar for the elderly.*

Toileting

There is a one toilet room with one toilet fixture. The room is located in the back of the house, midway between the kitchen and the living room. Thus, while the location ensures easy access to and from the toilet room, there is no direct visual access from the center's two primary program spaces.



The "powder room" off the kitchen.

Institute *Have you ever noticed any problems in that hallway between the bathroom and the stairs? What about for someone in a wheelchair?*

ADC 2 *No...it's not unusual to have maybe one person waiting. They'll stand there by the radiator and wait for a few minutes.*

ADC 1 *Definitely the need is here for more bathrooms....*

Institute *A few moments ago we were talking about how with eight people, one bathroom seemed overused.*

ADC 1 *Right. I've come when someone's had to wait. We have one member who uses it quite frequently.*

Institute *You would hate to have that lead to accidents.*

ADC 2 *It hasn't.*

Institute *Is that part of your strategic plan, to do some upgrades to this building?*

ADC 1 *No. First of all, how would we get people upstairs? I don't think it's an option to use that second floor space for members or anything other than storage. We've talked about it. At some point we may have to look at a different facility because the bathroom is a major issue.*

ADC 2 *You couldn't build from the existing house?*

ADC 1 *No, the family is very protective of maintaining it in its original form.*

Institute *So there's no way that you could knock out a wall and put in another bathroom?*

ADC 1 *We don't think so.*

Advice For Other Providers

Institute *We've covered so many interesting topics today. There's a lot here that we haven't seen in some of the other sites. We talked a little bit about the interaction with families. Is that important to you?*

ADC 1 *Oh yes, and follow-through, too.*

ADC 2 *Interaction among the members is important, as is community involvement.*

ADC 1 *Because of the community that we're a part of, and because of the size of our program, there's more personal involvement here than at a larger program. We can afford a more personal approach to caring for people. We can be flexible. We can treat people individually, with respect. We can take the time to deal with situations like the time when somebody came to the program in jammies or when they're not adequately dressed. We get them in the car, take them home, get them dressed and then back to the center.*

ADC 2 *And I think in the small community it's essential to keep that personal relationship, I really do. Everybody knows everybody, and they know we're going to take care of Mom and not let her sit in those pajamas all day.*

ADC 1 *What ever happened to the kitten that (one member) had brought with her one day? A day-old kitten wasn't going to survive in her purse.*

ADC 2 *She brought it in for us to take care of. She figured we could help it. She knew something wasn't right.*

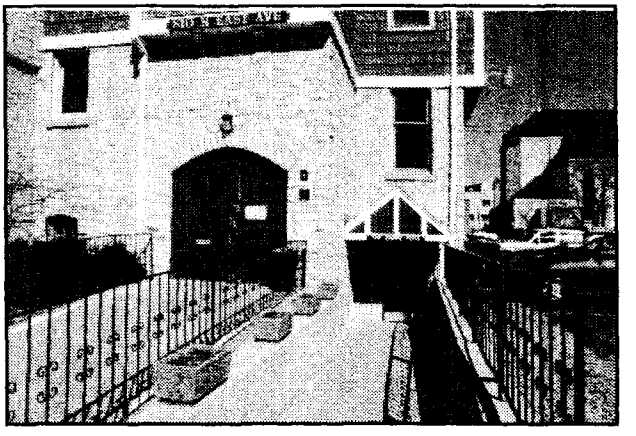
Institute *What happened to the kitten?*

ADC 2 *I asked the volunteer to take it to the vet. Apparently it had apnea the whole trip. But then they got to the Humane Society where there were dogs. And this little tiny kitten got up and started hissing right back. It ended up in a good foster home, a foster farm actually. Her family was very happy that we could help.*

The Caring Place
Waukesha, WI

Theme
The classic church basement.

What this case study shows:
- How a care provider adapts a program to a constrained physical setting.
- The limitations of adapted institutional space.



Place Profile

Director
Diane Graf

Site/context
Site is evocative of "Main Street U.S.A.," although in the past decade Waukesha has come to be considered a suburb of Metro Milwaukee.

Facility type
Adaptive reuse of church basement

Program space size
Approximately 2,700 square feet

Renovations
Initial adaptive remodel (1988), $125,000. Second renovation (1997) budget of $90,000 included expansion and design of quiet zone Carroll Room; redesign of kitchen and addition of island; interior (paint, vinyl floor and furniture) update of main activity room; modification of men's bathroom; and reorganization of existing office space.

Estimated cost/square foot
$80

Architect/designer
Walter Zoller, Waukesha, WI (initial remodel)
Fischer & Theis, Waukesha, WI (renovation)

Program

Mission and goals

The goal of The Caring Place is to ensure a meaningful day through flexible changes in activities to best suit participants' needs.

The lounge room.

General description

A mission of the First Presbyterian Church, The Caring Place began operations in the basement of its sponsor in November of 1988. Today, The Caring Place Adult Day Center is a non-profit organization governed by a 13-member board of directors. Diane Graf, the director since the program's inception, emphasizes the "activity focused" nature of the program, and notes there is an alternative "rehab focused" program located a block and a half away. Graf's program is structured around the premise that activities are adjusted to participant needs at three levels of competence.

Institute *As a day center specializing in dementia care, you've chosen to serve participants with a wide variety of strengths and abilities. What are the challenges?*

ADC *The challenge is that people change. When we set up the programming for the week and the month, we always have to take into account what goes on in people's homes before they come to day care. On a daily basis, we have to consider what kind of mood they're in. We may have to make adjustments because someone's had a bad night, or some trauma in their family, or is just plain having a bad day, or when people start to decline. Day care basically helps people maintain the current level for a longer period of time; occasionally someone might even get better. It just really depends on what the problem is. So the challenge is being flexible enough to change your activities to ensure that everyone can still have a meaningful day.*

If somebody was looking for a day program but needed to be in a bed, this would not be the program for them. We do have all these recliners... but those are what we use for rest time. It's worked out well because we've been able to provide some rest time and comfort for people.

The program operates from 7:00 a.m. to 5:00 p.m. Monday through Friday. It provides a hot noon meal, morning and afternoon snacks, activities and guest entertainers. Fees for The Caring Place are charged on a sliding scale that is keyed to an individual's income. The minimum daily charge is $26; maximum charge is $36. There is a $7.50 charge for a whirlpool bath.

Staffing

The Caring Place has a staff of eight (seven are full time). A staff nurse works three days a week.

ADC *We've been in existence for 10½ years, I've been here for 10½ years and the activity director has been here for 10½ years. We have staff who've been here 9 years,*

8 years and 7 years. And then I have three staff that have been here less than a year.

Institute *What do you think is the reason that they stay so long, that they don't burn out?*

ADC *I guess I'd like to think that they love their jobs. They work hard, and all days are not always great. It's still an opportunity to come to a job where you're appreciated by your employer and by the people that you take care of. I think we have enough staff. I know in most places all they say is "We don't have enough staff, we can't do this, we can't do that." Because of the type of program that we are, a small day care not connected with some big corporation looking to downsize or the budget won't handle this or won't handle that, most everything that we need we can have certainly within reason. I have a board of directors that care about the program and they care about the people that work here.*

I talk to many people who are always having staffing issues...that's really hard. It was hard for me this past year just hiring three people, when a staff person that had been here eight years left. I hadn't hired anyone in six years...I had people coming in and applying with nursing home experience making more money than someone I've had all these years. It was a real wake-up call for me and for my board. We made some changes. We added benefits; we brought up some of the wages. The environment has to be a place where you want to come to work every day.

Participant profile

The Caring Place has 55 enrolled participants, a maximum capacity of 22 and an average daily census of 20. Its participants range in age from 68 to 95 with an average age of 83. All its participants are Caucasian. Of all enrolled participants, 12 are male and 43 are female. Half of all participants are cognitively impaired. On average, participants require assistance with two to three ADLs. Thirty percent are incontinent, and 10 percent use wheelchairs.

Eligibility criteria require that participants be over age 50, can be transferred from a wheelchair with assistance of one or two people, do not engage in wandering, do not constitute a danger to themselves or others, and are bowel continent. Participants are accepted to the program on a one-month trial basis. Graf discusses the complexities of the enrollment process:

Institute *From the family perspective, what would you say is the rationale for enrolling someone in your program?*

ADC *I think the primary reason is that families want more for their parent or grandparent or spouse than to sit home all day and let the world pass them by. These aren't older people who are still driving cars and going to church groups and card groups and volunteering even. I'm talking about people who aren't able to hop in the car and drive somewhere, aren't able to pick up the phone and set up their own transportation, who aren't able to pick up the phone and say, "I'm going to have a few friends over." I'm talking about the population that has reached the point in their*

lives where they have lost the desire or the ability to motivate themselves anymore. Families feel badly that Mom is just sitting there all day staring out the window or sleeping, getting her days and nights mixed up. And then I think they also recognize that isolation just (kind of) speeds up that confusion and dementia and withdrawal. So those two kind of go hand in hand. I think also it's for respite... it's important if you're a caregiver who's home all day taking care of your mom or your dad or your husband--that gets to be really hard. You deserve to have a break whether you're going to sit in front of the TV and drink soda all day or go out with your friends or to a club or whatever.

Institute *If you knew that somebody had a very significant problem with wandering, would you have to turn them away?*

ADC *The difficulty is that families don't always know how serious it is. When you've been doing this as long as I have you tend to pick up on some of the answers that families give you. That's why we have a one-month trial basis. And also it depends on how often they come. If you enroll somebody in a program whose dementia is a little more advanced and they tend to wander, you really want to encourage those people to come at least two days a week. Because if they only come one day, every day is a new day. And it takes a month or two before the anxiety wears off: "Oh, okay, I don't know where I am, but I know I've been here before and I feel good. It's okay. I feel these people will be good to me." So, that's another part of the enrollment. I encourage them to enroll for two days a week. We've had a couple of gentlemen recently who had just this problem. They were appropriate for the program, but it just took longer for them to get acclimated because they were only coming one day a week.*

Physical Setting

The Caring Place operates in the basement of the First Presbyterian Church, a building that is registered as an historical landmark. Exterior modifications are prohibited due to the building's historical status.

The Caring Place's program spaces consist of the dining/activity room, the lounge, and the benefactor-named Carroll Room. The open kitchen is located along one wall of the dining/activities room. The director and activities director share the program's one office. Separate men and women's restrooms and one bathing room complete the space.

To enter the day center, one follows an outside wheelchair ramp through a solid, exterior grade fire door and down an interior ramp that faces the men's bathroom and opens directly into the dining/activities room. The ramp is surfaced with Flo-tex carpeting.

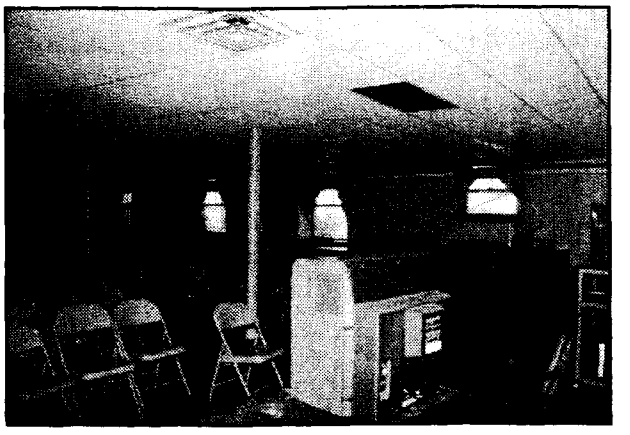
The dining/activities room is one large open space, furnished with square tables and light wood arm chairs with vinyl upholstery. Floor-to-ceiling white laminate storage cabinets line two walls. The room has a dropped acoustical ceiling, fluorescent lighting and vinyl flooring.

The open concept kitchen is defined by the placement of a long central island, which has storage cabinets beneath the work surface. It features residential-style wood laminate cabinets, refrigerator and range, though the dishwasher is commercial.

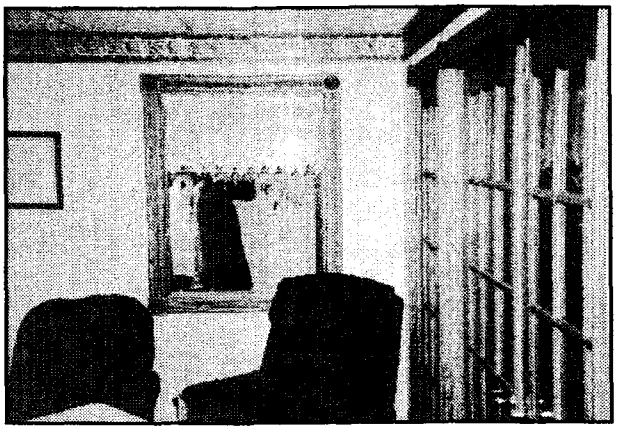
Separate men's and women's restrooms are located behind the kitchen; entry to these rooms is from the dining/activities room. Both rest rooms have white ceramic tile and fluorescent lighting. The women's room has three ganged toilet stalls, each outfitted with grab bars; one stall is slightly larger to accommodate wheelchairs. The men's room has two toilet stalls: one standard, the second ADA compliant.

Adjacent to the Carroll Room is a corridor where coats and personal belongings are stored out of view of participants. This corridor leads into basement space reserved for the church.

Also opening directly onto the dining/activity room is the bathing room with one tub. A curtain provides visual privacy. The room has white ceramic tile on the walls and floor. Lighting is fluorescent.



Program space set up for musical entertainment.

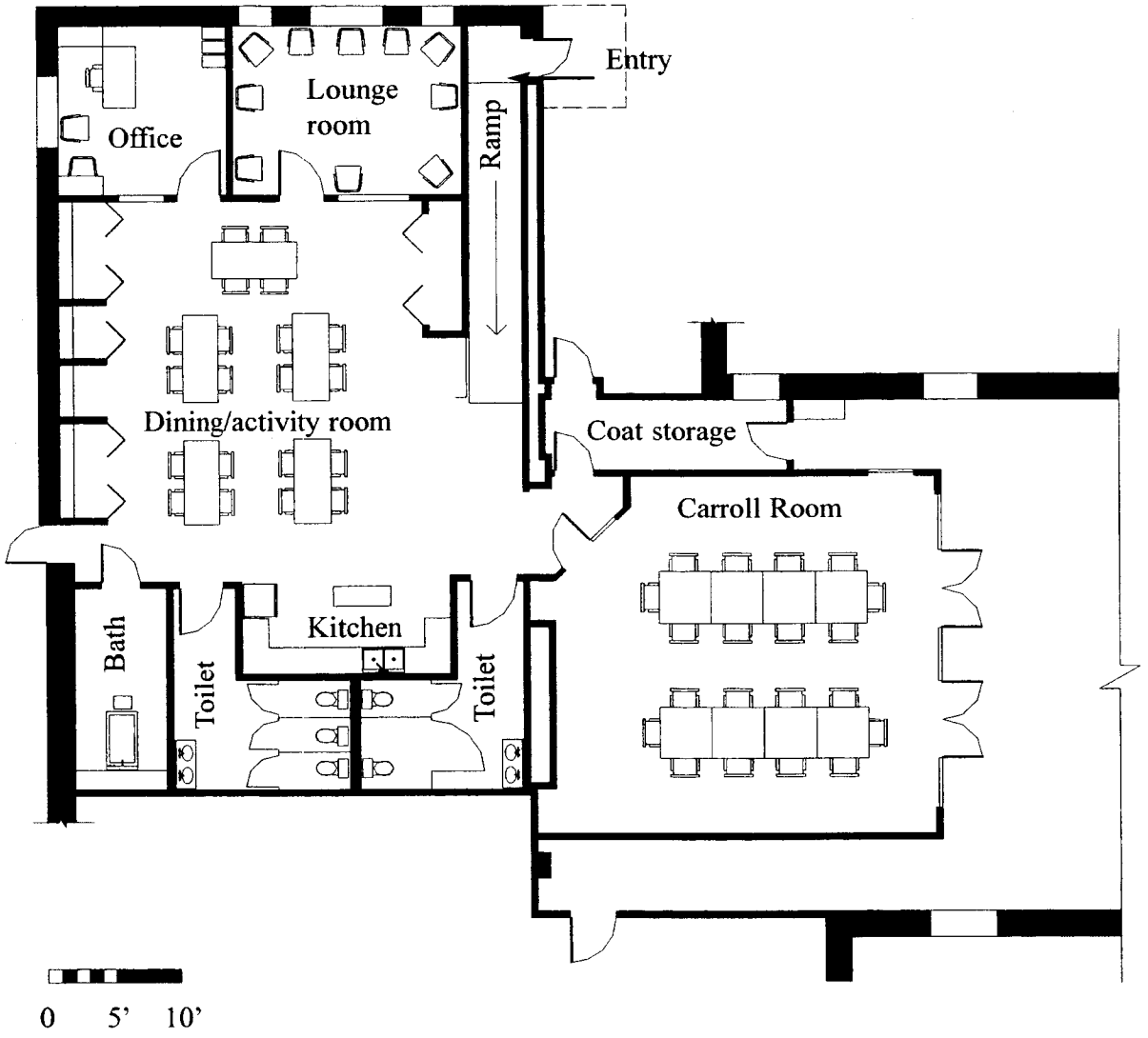


Carroll Room with interior window.

The lounge room is furnished with recliners arranged around the periphery of the room. The room has Flo-tex carpeting and a dropped acoustical ceiling, which cuts across the two double hung windows placed high on the wall. The view of the parking lot is obscured by opaque glass block. An interior window looks out onto the dining/activities room.

The Carroll Room can be seen from the dining/activities room through a French door with glazed sidelights. The room has a dropped acoustical ceiling, sconce lighting and Flo-tex carpeting. Custom laminate cabinets along one wall provide storage for wheelchairs. Furnishings include square tables (which can be folded for storage) and wood dining chairs with fabric upholstery. There is an interior window that admits light from a window on an outside wall. The room's back wall features a set of French doors that open onto the part of the basement space usually reserved for church use. Darkened when not in use, this space is employed occasionally for joint day care/church activities, such as holiday music programs or when groups of school children visit.

Floor Plan: Caring Place



The Place In Use

Coming and going

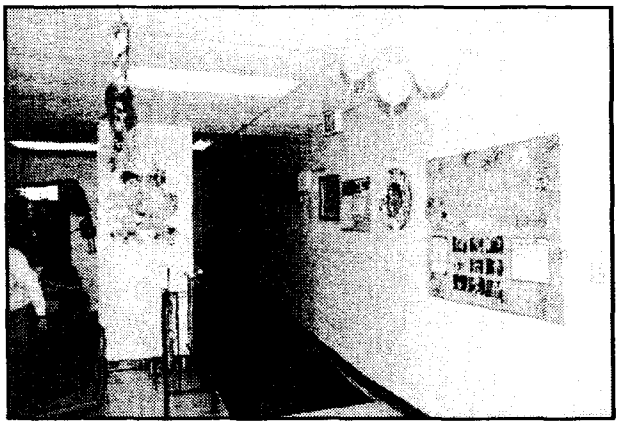
On a typical day at The Caring Place, the first participant arrives as early as 7:00 a.m., although most arrive between 8:00 and 9:00. Until four years ago, participants were brought to the center by their families or taxi. Recently, Waukesha County (subsidized by the Department of Aging) has begun to provide van service, with fees based on income and distance to facility. Graf acknowledges the safety and reliability of the van system, but laments the loss of connection to participants' families.

One descends into the basement-level facility down the wheelchair ramp. Graf comments on the drawbacks related to the entrance:

Institute *Could you explain the difficulties you experience with the ramp and no vestibule?*

ADC *These limitations are mostly because we're housed in a church and this is a landmark building...they had to get permission from the Landmark Commission, and this was the best that they could do. The first issue is the door. For one, the door itself should be a little wider. What they didn't account for is people coming in wheelchairs with their foot extensions on--they stick out a little bit. So when they have to get around that corner, it's a little tight. That's coming in and going out. And whenever maybe four or five people come in at once there's a back log. It's always, "Okay come on, step on in, walk on in so the people behind you can get in." The other problem is in the winter: The door is automatic and opens for about 10-15 seconds. That rush of cold air comes down and while we aren't in this main activity area all the time, we are certainly a portion of the time. People will start asking, "Where's that cold air coming from? I'm really cold." We say, "It'll be only a couple seconds and it'll be okay." You know we probably go through that 20 times every morning in the winter. Also (the ramp) is just like a little tunnel coming down here, not real welcoming... you have to get all the way down the ramp into the main activity area before you feel a sense of warmth. So we just get people in the door. One thing we're planning is to have some art students paint a mural on that hallway to warm things up some.*

Although most participants typically leave between 3:45 to 4:30 p.m., usually the last departure is at 5:00. The day's final activity is held in the Carroll Room. As each driver arrives, participants are escorted individually and prepared for departure, while other participants are kept busy with the activity.



Descending the entrance ramp into the program space.

Institute *The entrance door is not visible from the activity area. Is that an advantage?*

ADC *Oh yes, it's a definite advantage. I know some day cares have...I mean because we're on a lower level here some people might feel that we don't have access to the outside and people can't see what's going on outside. But that's really never been an issue here and I think it could be a problem if they were watching what's going on outside all the time. Unless it's looking outside into a garden or something. There's another day care that opened two blocks from here and it's on a busy street. I would think that people would be always looking for their person to come to pick them up.*

Here, the door is not something that they're looking at or watching all the time--it's worked really well here for us.

Primary program spaces

At 10:15, multiple activities are conducted concurrently in the dining/activities room and the Carroll Room. The lounge room is used for rest time as well as scheduled quiet activities. Participants are divided into three groups, generally by cognitive/ability level, although interest (or dislike of, for that matter) in a particular activity is also taken into consideration. Group sizes are predicated on activity, activity level and participant's ability level:

ADC

The ideal number depends on what you're doing. If you are in this room and doing a reminiscing group or a share time, the most you would probably want is seven or eight. Or let's say it's an active game and there are two people leading, you could probably handle 12 people on two teams. One team on one side and one on the other. So it really depends on the activity. If you're doing a craft you may want only six people with one staff person and one volunteer. If you are working with a group of people that are on a little lower level who need a lot of assistance.... It just kind of depends on what you're doing at the time.

One of the buzz words in adult day care these days is "choices," and certainly for older people there are fewer and fewer choices in life. So while we do break up into groups most days, today for example, our music therapist is coming so we'll just stay together. We pay her to come and it's something everybody partakes in unless they just hate music. She's been coming for years; they love her. There's always a chance that someone will say, "I don't like music, I don't want any part of it." It's not realistic to think you could go to all 22 people that we have here today and say, "What would you like to do today?" Plus they may pick something that is too difficult for them, and failure is not something you want them to feel while they're here.

A lot of our programming is based on the staff's knowledge of each person and his or her skills. When it's a new person, we will say to them, "This is what we're doing today. What would you like to do?" Maybe of the three or four things we're doing, maybe two they can participate in, and maybe two they can't. They have choices. If we feel it's not working or they don't like it we can simply say, "You know next time we're going to make sure you're not in that activity, that we do something else." And they forget about it. Other times when you see it not working for someone, we've offered an option, for example, "Do you want to go in with Pam instead?" We're giving them choices. It doesn't happen all that often, because the girls have a good handle on the people and what their abilities are. While that may not be the answer you're looking for, you have to be realistic. None of us can go anywhere and do whatever we want. In order for 22 people to have a good day, you have to have some structure, but yet flexibility. We can offer choices because we have the main room, the lounge room and the Carroll Room. We can do it because we have four staff in the morning. There's always going to be something that somebody likes to do.

In comparison with many other adult day centers, the activity level at The Caring Place is somewhat dynamic. The director talks about strategies for dealing with reluctant participants:

Decorations for a holiday celebration.

Institute *If they don't feel like engaging in an activity at all, are they encouraged to participate anyway?*

ADC *It's okay if they want to come in here and rest; sometimes that happens. If someone didn't sleep well or they're just not feeling well...this happens sometimes with our people who have depression. We serve quite a few people who have depression and a history of depression. Sometimes they just need to have a little quiet time to themselves. They have rights and if they decide they don't want to do something, we don't force them. If it becomes a continual problem or there's a pattern developing, then we would talk with the family or social worker, doctor or whatever. Sometimes it's a medication change. I stress in our program, and I know this isn't the case in other programs that are more medical intensified, that our program involves a level of participation. I would not enroll someone in the program if the family said to me, "I just want my mom to be safe. I don't care if she comes and sleeps all day and doesn't do anything." I would say, "But we care, and that is not the kind of program we are." There are programs that will allow you to do that, but this just doesn't happen to be that type of program. So certainly if someone is having a day or two where they're not up to it then that's fine. Sometimes when new people enroll and they come from hospitals or are discharged from a nursing home you can't expect them to jump right in and handle the whole day. They may need a couple rests during the day, and that's something we certainly accept.*

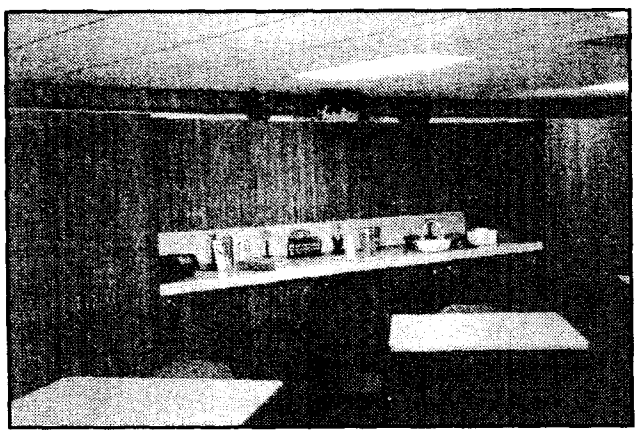
Institute *How often do people get visitors? What's the policy on that?*

ADC *Some of our participants have social workers come here to visit them when they need to make contact. The social workers like to do it here because they feel that they can see more people if they come to the facility. There's a couple of issues connected to that. Of course, I understand their position, but our stance is that participants have paid to come here for the activity, and when you pull them out of an activity that they like they're not very receptive. So, I encourage the social workers to make their visits during the times when people are not here at day care, but certainly I make it available if necessary.*

Sometimes the family will say, "My mom's other daughter is in town today; could they stop by and see her?" Well sure they can--maybe we'll make the lounge room available for them to sit, or just try to find a quiet spot. Sometimes they can engage in the activity that we're doing at that time and kind of participate in it. It just depends. It doesn't happen all that often. As I said, we try to encourage people to schedule those visits at another time, because say a person comes to day care maybe two days and they're home the other five days, maybe it would be better if you went and visited them at home. So we'll accommodate, but I don't encourage it.

Toward the close of the day, participants are gathered in the Carroll Room. Departure is on everyone's minds, and the related commotion generally causes some anxiety:

ADC *The last activity of the day is really the snack they get at 3:30. After that, people are trying to wind down and talk about the day. It's also the time of the day when all the staff are together. It's kind of like "all hands on deck" attitude here. Maybe one of us will be sitting at a table with folks talking, trying to distract them, reassuring them, "That's not your driver, it'll probably be the next." It's just a constant challenge, some people are okay with it and some aren't.*



Accessible kitchen open to the dining/activity room.

Kitchen and kitchen work

The kitchen at The Caring Place is open in concept. The central work island allows staff to face the main activities room while they are preparing food. Coffee is available throughout the day, and participants enjoy a morning and afternoon snack prepared on site.

Institute *Do you like the open kitchen? Are there any problems with it?*

ADC *The only problem we have with the kitchen is at mealtime when we're doing our exercise activity. It's a little distracting to have staff getting ready for lunch over there while people are doing something else in the room. We've dealt with that by rearranging people into two rows facing the activity leader, instead of having a circle. The down side of that is when you're in a circle you can get your ball out and do more. When they're sitting in two rows you can't do that. You just have to adjust, think about what we did this morning. Do they need more exercise or will doing stretches be enough? Day care certainly isn't winging it, it's really planning -- that is, if you're conscientious and you want everything to go well. I suppose it doesn't have to be that way. Having the kitchen there is great for serving the meal. It's very, very convenient and it stimulates their senses because if they have cooking or baking*

they can smell that. We love having the kitchen; we just don't like it at exercise time.

Institute *Do any of the participants participate in the kitchen activities?*

ADC *The volunteer sets the tables for lunch because people are involved in exercise. After lunch we do have some people who like to pick up the placemats. They like to gather those and put them in a pile, put all the dishes in the center. Some like to pick up a few dishes and bring them to us; we let them do that. As far as actually doing the dishes we have an automatic dishwasher, a commercial one that's so hot we really can't let them in there then. When we do baking groups we don't use the dishwasher. We let them take care of the mixing bowls and those kinds of things, because it really hasn't been in their mouth. You know that's the big issue. They like to put away the dishes and so those kinds of things they can help with, but not actually in serving the food.*

Dining

Lunch takes place at noon in the dining/activities room. All participants are seated in pre-assigned seats at tables of four or six each. Lunch, which is prepared and delivered under contract by the local hospital, is plated individually on site. Lunch is served on china plates, with glassware and metal utensils. One staff member or volunteer is seated per table to provide meal assistance.

Toileting

The Caring Place has two toilet rooms with a total of five fixtures. The newly renovated men's room has two stalls, one standard, another ADA compliant. The women's room has three stalls, one of which is slightly larger and can serviceably accommodate a person in a wheelchair or a two-person assist. Doors to the toilet rooms are kept open throughout the day.

Men's toilet room.

Institute *The restrooms open right into the activity area. What problems does that pose?*

ADC *The bathrooms are original and that's really why they're there. It certainly isn't the sort of thing that you want to see right away when you walk down the ramp. The doors to the rooms are kept open because so many of the people have walkers, and if the doors are shut there's always that risk of them being bumped and getting knocked over. The other problem is that you want people to have as much independence as they can and if you shut the doors, that means that you are always going to have to be there opening the doors and that means that people who are*

otherwise independent may become dependent. If the bathrooms were in another location it wouldn't be an issue.

Institute *Do you think visibility is an advantage?*

ADC *In thinking about other centers that I've visited, for example in a church that's now a day center, the bathrooms are down a long hallway and I imagine that is a disadvantage. People wouldn't be able to find it independently. So in some ways it's a little more positive than negative.*

Institute *You have stalls in the restrooms. Does that work?*

ADC *The ladies' room has three partitions; one is pretty much saved for wheelchairs because it's wider. They all have the grab bars for safety. One has a riser on it. The men's room has just two partitions: the one partition is a standard size and the other partition is up to ADA standards after renovation and it's wonderful. You could fit even three if you had to: we've already had instances where it took one person to hold the wheelchair, one person to hold the person up and one to help them with clothing. We do use it co-ed sometimes, not that there's a man and a woman in there together, but for example on Thursdays we have one man, and we always say, "Gil, can we use the bathroom now?" It's just kind of cute, because all the ladies are in there. It works that way.*

A place for personal care is provided in the lounge room.

Bathing

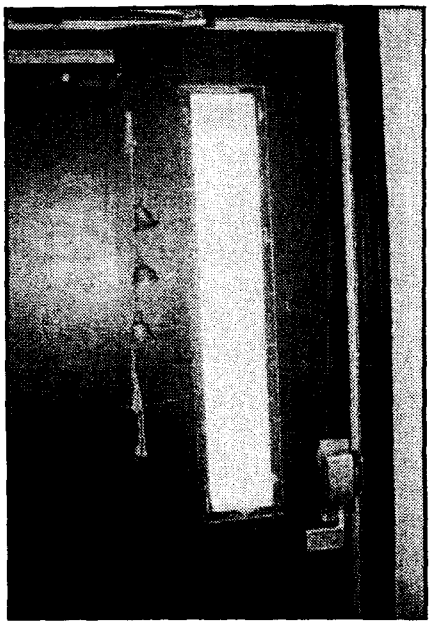
The Caring Place has one tub, located in a room that also opens directly into the main program space. The door and curtain around the tub ensures visual privacy for the participant being bathed. An average of five baths are given each day.

Wandering

Wandering has not been an issue to date, in part due to organizational orientation that discourages wanderers from enrolling. Chronic wanderers are not accepted to the program. The director defends the policy and considers wandering counterproductive to the welfare of participants as a group.

Institute *You've said there are some people who might wander: How do you deal with that?*

ADC *In our experience the difficult time has been after lunch when there's a 45 minute window where we have a rest or quiet time. Basically there are people in the lounge resting or in the Carroll Room playing cards or crocheting quietly, and staff is cleaning up from lunch and kind of getting ready for the afternoon activity. So it isn't a structured time, and that's difficult for some of our people with dementia, because they require one-on-one or have to be occupied by an actual activity. As a staff, we have to adjust and make sure there is one staff person who is handling the one, two, or three people that need a structured activity. Some people just can't handle the unstructuredness of it. We have to pay attention and that's what we do.*



Low-tech but effective alert device.

Advice For Other Providers

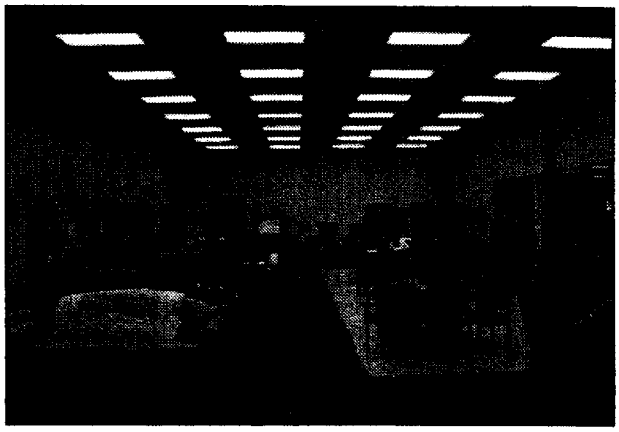
Institute *As a lesson for other day care providers, what would you say are issues related to being in a church basement?*

ADC *This day care began as a mission of this church, so that's a real positive because the church as a whole has a vested interest in what's going on here. Before I came here I worked in another day care in a church, but it was not a mission of that church. It was just space that the church had decided to rent out. There were numerous problems: Sometimes they maybe didn't clean up properly afterwards or people got into their supplies. Other times there would be an activity going on that night at the church and the people wanted to use the kitchen and maybe the day care people were in it. Well, that isn't a problem here because this space is not shared. All of this space is day care space. So that is beneficial to us. If we had to open up this space to all church functions and the public in general, like a lot of churches do, it would be a huge problem. They wouldn't take care of your equipment, your furniture, or clean up after they use your space in the evenings. There would be scheduling conflicts sometimes. So I guess if you're going to start a day care in a church, you want to make sure that the guidelines are set up ahead of time of who can use that space when you're not in it, what the priorities are, whether you're sharing equipment and sharing upkeep expenses.*

Elder Care of Dane County
Madison, WI

Theme
Recycled space.

What this case study shows:
· The challenges related to having a program on the second floor of a building.
· Issues associated with unwanted environmental stimuli, in this case, the noise generated by the activity of a nearby airport.



Place Profile

Director
Sharon Thornburg

Site/context
The facility is located in an industrial park on the southeast edge of Madison, WI, near the municipal airport.

Facility type
Adaptive reuse of a commercial/office building with adult day center on the second floor

Building size
Day care alone: 9,500 square feet
Building total: 16,500 square feet

Renovation
Conversion of office space for adult day center, rehabilitation services and administrative offices

Estimated cost/square foot
Approximately $15

Architect/designer
TJK Construction and Design, Madison, WI

Program

Mission and goals

Elder Care is a site associated with On Lok and the Program of All-Inclusive Care of the Elderly (PACE), a comprehensive service and financing model for long-term care of the frail elderly. Established in 1971 by On Lok Senior Health Services in San Francisco, PACE sites provide team-managed care to the significantly impaired, frail elderly. The PACE model, which is based on capitated financing from Medicare and Medicaid, offers an integrated program of acute and long-term health services in both inpatient and outpatient settings. By definition, PACE centers are staffed by an on-site physician and other medical professionals who are capable of providing the range of care

services typically required by an elderly population. For example, Elder Care's site houses physical exam and sick/respite rooms, a blood draw facility, pharmacy and rehabilitation area as well as ancillary space for medical records.

General description

Located in a renovated office building in a commercial/industrial area immediately adjacent to the municipal airport, the two-story facility houses the adult day center program on the second floor and a rehabilitation clinic and pharmacy on the first. This is one of three Madison sites operated by Elder Care of Dane County, which is a non-profit quasi-governmental agency that has been providing adult day care since 1972. Elder Care's other sites are located on Madison's west side. One program is located in the basement of University Heights Presbyterian Church, another occupies the second floor of the Attic Angels Nursing Home. Elder Care provides services to its participants from 7:30 a.m. to 4:00 p.m. Monday through Friday.

Staffing

Elder Care has a staff of 11 full time employees in the adult day center. Staff to participant ratio is 1:5. The rehabilitation clinic and pharmacy are staffed separately.

Participant profile

Although Elder Care draws its participants from an estimated 15-mile radius surrounding the facility, participants must be residents of Dane County to be eligible for covered services. It has 96 enrolled participants, and an average daily census of 52. Maximum capacity is 78.

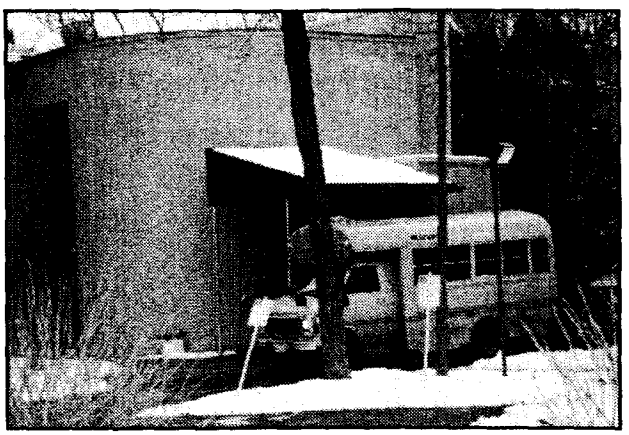
Elder Care participants are 55 years and older, with an average age of 73. The gender ratio of participants is one male to eight females. Sixty-one percent of participants are white, 32 percent are black, five percent are Hispanic and two percent are Hmong. Cognitive impairment affects 41 percent with most of these individuals in the early stage of dementia. Thirty-one percent of participants use wheelchairs. Twenty-four percent are incontinent, and the majority are dependent in three or more activities of daily living.

Physical Setting

Elder Care is located in an office park near the county airport in Madison, WI. The building that Elder Care occupies was constructed in the late 1980's and originally intended for commercial and light industrial purposes. The building is situated next to a lightly wooded area and shares a parking lot with a neighboring office complex. Following renovation, Elder Care moved into the facility in May 1997.

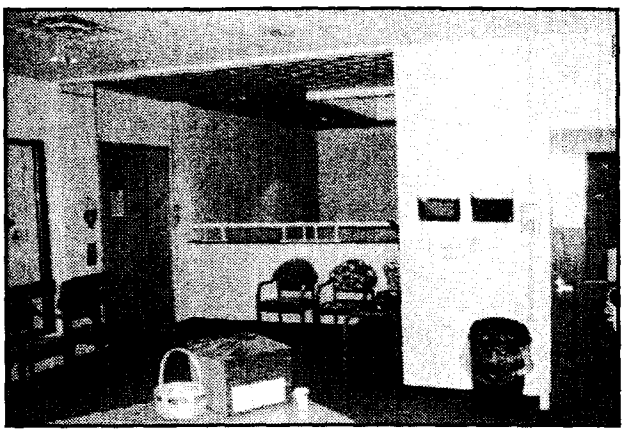
Elder Care occupies both levels of the building, with administrative offices located on the first floor, and the adult day center and rehabilitative services area on the second. The building is faced with wood siding painted a light brown.

A small canopy offers protection at the main entrance to the facility. The canopied entrance leads to a small assembly area (staffed during morning arrival times). This assembly area leads to the elevator, stairs and administrative offices on the first floor. A secondary entrance offers a direct entrance to the elevator and administrative offices.



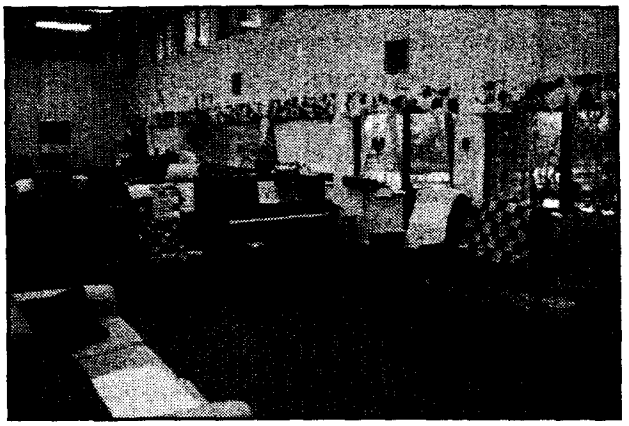
Van canopy at entry.

To reach the day care program space, one takes the elevator or stairs, both of which terminate in a second-floor central entry area. This area contains a reception desk and space for coat storage. To the left of this entry area is Rehabilitative Services, to the right is the adult day center.



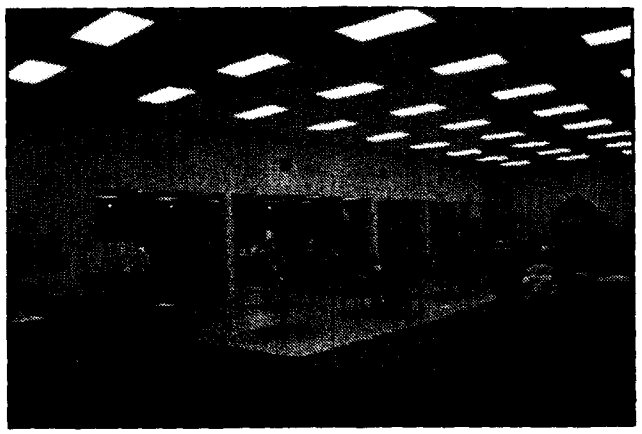
Central entry area on the second floor.

Elder Care's adult day center encompasses a large central activity space, kitchen, offices for day care staff, bathing facilities, toilets, storage and a smaller group activity space. The central space has six activity-defined areas: the aviary, the radio, the piano, cards/puzzles, crafts, and the computer. The dining area juts into this central activity area. The walls of this central space are painted off-white and decorated with hanging plants and several varieties of crafts, including window valances that were made by participants. Natural light is admitted into the double height space via two rows of fixed windows fitted with horizontal blinds. The ceiling is acoustical tile with fluorescent commercial-style lighting fixtures. Some of the smaller activity areas have supplemental lighting provided by residential-style floor and occasional lamps. The floor is covered by a tan-colored low pile carpet.



An activity area defined by furniture arrangement.

The dining area is furnished with circular pedestal-style tables and contemporary cloth-covered chairs. The decorations include a large quilt hung on the wall, a small commercial-style popcorn machine, and a number of small craft objects. A commercial-style sink (a remnant from the building's light-industrial days) in the dining area is used by staff and participants. The dining area is marginally defined from the central activity space by sheet vinyl flooring. A lower acoustical tile ceiling with inset fluorescent lighting extends only over one-half of the dining area; the remainder is double height.



Floor finishes marginally define the dining area.

The small activity room.

Meals are prepared off site and reheated/plated in the kitchen; snacks are prepared on site. A pass-through window located between the dining room and kitchen is secured when not in use by a metal tambour door. The monthly activity board, which lists upcoming events and news about the ADC staff and participants, is mounted next to the pass-through window. Adjacent to the kitchen are a small activity room, offices of the ADC administrator and staff, a storage closet, and staff toilet room.

The personal care area consists of bathing facilities, hair care area, personal garment storage, commercial-use clothes washers and dryers, and toilets. The men's and ladies' toilet rooms with two fixtures each are standard, with space for a one-person assist.

Elder Care's bathing facilities consist of two large shower rooms, each containing a wall-mounted hand-held shower fixture, vinyl and stainless hospital shower seat, and toilet. Rather than having a separate shower enclosure, the room itself has been designed to serve as the enclosure; the shower room floor. Given the expectation of a high level of moisture exposure, the rooms are sparsely decorated and, as interior rooms, have no access to natural light. Each shower room has a supplemental curtain covering the door to provide additional privacy. The flooring is beige ceramic tile and the walls are larger white ceramic tiles accented with a horizontal tile detail at eye level. Toilets are outfitted with movable grab bars and enough space on each side to accommodate a two-person assist or Hoyer lift.

Adjacent to the shower rooms is a personal care area outfitted with a salon-style chair. This area is utilized by both male and female participants for hair washing, cutting and other personal care needs.

Also located in the personal care zone is a storage area in which participants' personal items and extra clothing are stowed. There is additional organizational storage in a large closet and cabinets for bathing and toilet supplies. Two industrial-style washers and two dryers are used for cleaning towels and participants' clothing as needed.

Institute *Why did Elder Care choose this site?*

ADC *Initially it was because of cost. We were able to get a very good deal on this building. We weren't able to find anything on the west side that was comparable.*

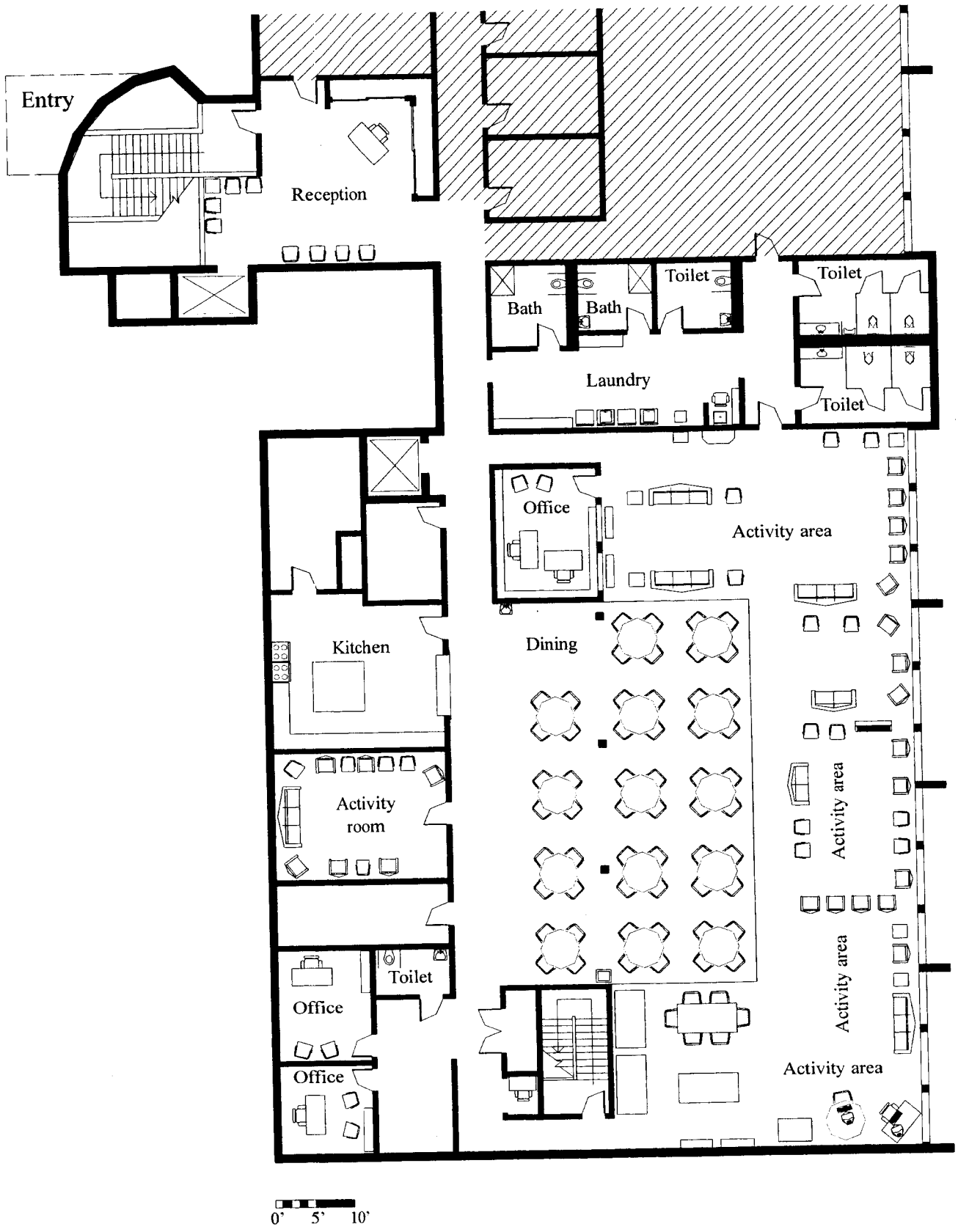
Institute *We're near an airport, and I notice the noise at times from airplanes going over. Is that necessarily a problem?*

ADC *In the wintertime you don't hear it. I think it's like anything: You eventually get immune to it. In the summertime when you're sitting outside around the picnic tables and you're trying to have staff meetings it can be irritating, but other than that it's not a problem.*

Institute *So not a problem from inside?*

ADC *No. I think when we first moved in you heard it, but then it's like anything else, you get used to it after awhile. Outside you can hear it.*

Floor Plan: Elder Care



Coming and going

Unlike many other adult day centers, Elder Care chooses to own and operate its own vehicles for participant transportation. The center currently has nine vans and hopes to purchase three more in the next year. Six to seven day care participants are transported per trip. Though director Sharon Thornburg estimates each transport trip averages around $17, this figure is still less expensive than through outside contract.

The front entrance to Elder Care.

Institute *We noticed you don't have a covered entrance. Would you prefer one?*

ADC *Ideally yes, it would really help especially...when the rain is going to turn to ice. For safety precautions, you bet.*

Institute *How do you deal with rain or snow in terms of getting participants in and out? Is the van driver assisting people, or is there staff that also helps?*

ADC *There is a combination of both. Early in the morning we have health care workers downstairs who meet the vans, so there are several people helping with the transfers of that need. Also, (we do things like) keeping it wet with salt.*

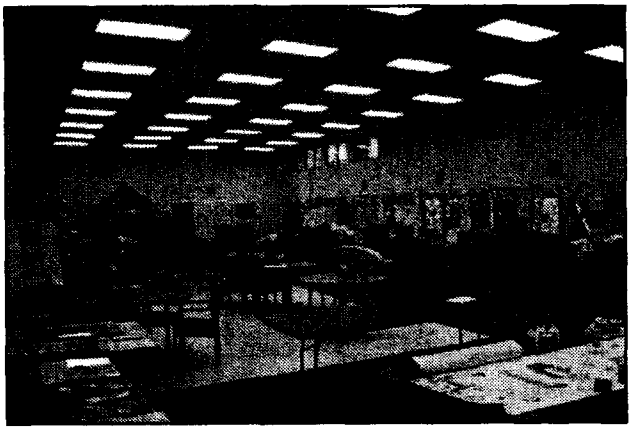
Despite the challenges intrinsic to the second floor location of the day care program, a workable process of arrival and departure has evolved. A health care aide is stationed at the first floor entry through the morning "rush" of day care participants, usually until 10:30 a.m. Participants are assisted from the van into the building with the help of the aide and van driver. Participants are then ushered into the elevator (or up the stairs for the more able) to the second floor. Once on the second floor, another health care aide helps remove and store participants' coats, hats, gloves and boots in the vestibule. From there, participants are led into the primary program space where they spend their day.

Afternoon departures have a markedly different tone. As vans approach the center, drivers radio the day care program transportation coordinator, who alerts staff by pager or overhead PA system. This announcement signals staff to dress that van's participants for departure. After being helped with their outerwear, participants are seated in the second floor coat area/lounge until they are retrieved by their van driver for the trip home.

Institute *Could you comment about the difficulties of having a first floor entrance and participants on the second level?*

ADC *This is not the ideal setting. There are difficulties. It would be much more efficient*

if we were all on one level. The bus drivers would not have the frustration that they do of having to go up and get people. It takes time out of their day, and we could be better at having participants up and ready to go.



A view of the activity area.

Primary program space

Elder Care's primary program area consists of a single structurally undifferentiated space. It is furnished with a variety of chairs and tables in assorted styles and materials. Adjacent is a separate activity space in what was once a conference room. This space is used for small group activities, for example therapeutic discussion such as the Men's Stroke Group, or current events/daily newspaper review.

Institute *Overall your thoughts on the one large space: advantages, disadvantages?*

ADC *It's very noisy. There's no privacy and that can invite disrespect. If you want to ask somebody if they need to go to the restroom or whatever, there is the potential of being heard by all. It's not real conducive to being friendly and you have to be real aware of what you're saying and what you're doing. Voices carry. Even the health care workers have to be astute to what they're saying.*

Institute *How do you refer to the space?*

ADC *We call the second floor the "day center." It's just called "day center." In regard to activities, yesterday it was wonderful. We had two groups going on. We had an activity going on at the table out there and then in this room here we had another activity going on. All the participants were participating in something.*

Institute *So are you pushing for that to be the norm: two activities going on at one time?*

ADC *Yes.*

Institute *In terms of the furniture arrangements, it looks like the larger room has been set up for a couple of concurrent activities. There's a smaller area off to the side with seating and another grouping adjacent to the TV, and a long table toward the other end of the room. How do you use these areas? How do you decide which activities happen where?*

ADC *The activities people usually decide it. And of course they make their decisions based on the space that's best for the activity.*

Institute *We've observed people just sitting quietly, not being part of an activity. Do you generally try to get everyone involved? Do you give them a choice?*

ADC *It's all in your approach. If your staff is truly trained in activities, they will know how to motivate people. So part of it is getting the skilled staff. It's a choice, but you really try to get people to participate. If they say no, we honor that.*

Rehabilitation area

PACE sites offer a variety of healthcare-related services to the elderly and physically impaired over age 55. Elder Care has experienced a steady demand for both pharmacy and rehabilitation services. On physician's orders, therapy sessions are provided to both day care participants and on an *a la carte* basis to individuals from the community at large.

PACE rehabilitation area.

Institute *Since this is the only PACE site we're looking at in this project, we have some questions about your rehab area. It's large. How suitable is the space for your needs?*

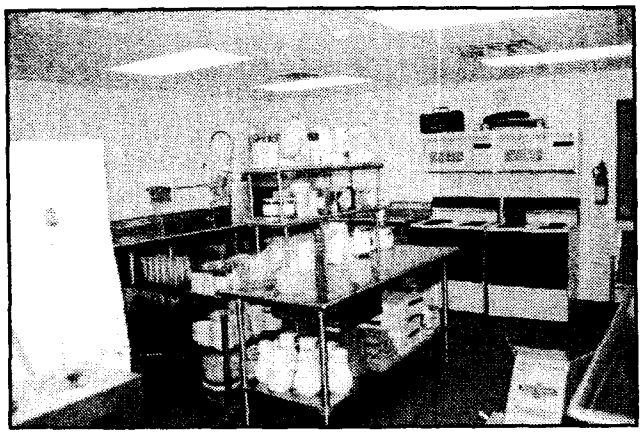
ADC *According to the therapists we need more room. We don't have the space we need for all the walkers and the wheelchairs. Now we're trying to think about getting a shed built to put the wheelchairs in...yeah, we need more space.*

Institute *So a lot of space is used for storing things like wheelchairs and therapy equipment. Is there enough space to do things in terms of therapy?*

ADC *They'd like to spread out a little more, considering all the activities that they do back there. They have an exercise bike, they've got the therapy machines, they've got the balls that you sit on for coordination and they've got the walk bar. With the amount of therapy work they have coming in here, though, they really could use more space.*

Institute *If you could change anything about the rehab area, what would you change? Do they need more space or a change in the way they use the space? Do they need something specific?*

ADC *What they would love to have is a dressing area where participants could actually go in and change their clothes or whatever. They talk a lot about that. They need an area that looks like an apartment so that they can do some teaching. Those are two things off the top of my head that I know are on their wish list. Just like with the rest of the building, they're meeting the needs of their clients....*



The kitchen is used primarily by staff.

Kitchen and kitchen work

The kitchen at Elder Care was formerly a conference room. This space is rarely used by day care participants. The noon meal is delivered in bulk to the facility and plated by staff in the kitchen. Morning and afternoon snacks are also prepared by staff on site. The pass-through window is used to set out beverages and snacks for participants throughout the day. When the kitchen is not in use, the pass-through window is closed by the metal tambour door.

Institute *Is the kitchen a noise generator in terms of food preparation and dishes?*

ADC *Yes. When it's time to wash dishes that dishwasher sound just comes right into the activities room.*

Institute *The kitchen area is totally for staff use to prepare the meals?*

ADC *Meals are brought in so some of the equipment we have back there we don't need. I'm not sure why we ended up with two ovens...*

Institute *You don't use it?*

ADC *Not the two ovens. We use the microwaves, but most of our food is brought in, other than the snacks and the breakfast snacks.*

Institute *Do you ever have participants engaged in an activity in the kitchen?*

ADC *Not to the way you would like to envision it. We have people out at the table (in the primary program space). Rehab will have an activity where maybe they'll peel apples and make an apple pie at the table and then Mary bakes it. They might make ice cream out of a coffee can. But those activities are all taking place out at the tables.*

Institute *Would you prefer to have a kitchen that participants could use in some way or do you see your population as too physically or cognitively impaired to do that?*

ADC *I would like to have a kitchen available for several reasons. There are those that do like to cook. There was one lady who was excited about making the dressing for the turkey for the Christmas holiday. We let her do that back there. There are also times we need to assess whether or not our participants can live alone and it would be really nice to have a kitchen that we could say, "Go in and fix a meal" and see if they could cook.*

Dining

Dining activity at Elder Care consists of a morning snack, noon meal and afternoon snack. As noted, the dining room is ill-defined spatially. The arrangement of dining tables and chairs extends out from under the area with the dropped ceiling and well into the primary program space.

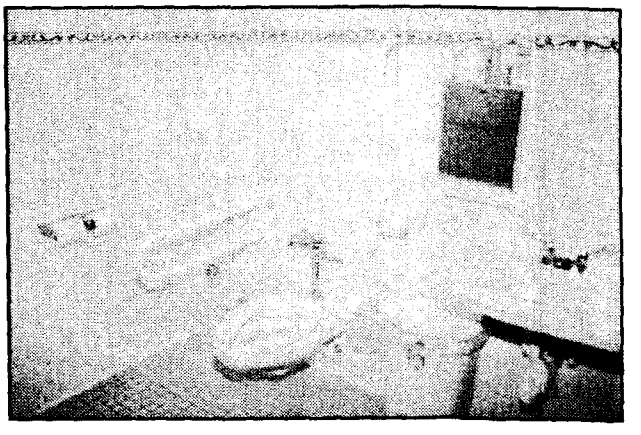
The dining area extends into the primary program space.

Institute *In terms of dining there are groups of three or four to a table. Are they able to choose where they go to sit, or do you have some direction?*

ADC *It just turns out...that those that aren't as cognitive end up together by nature, because you end up feeding some of those people. For the most part there is choice and there are groups that want to sit together and socialize. That's fine. We encourage that.*

Toileting

To accommodate its average daily census of 52, the facility has a total of seven toilet fixtures and a urinal. Two rooms have two ganged stalls each. Adjacent to the personal care area are two shower rooms outfitted with toilet fixtures as well as a third bathroom with toilet and tub (which is currently being replaced by two shower fixtures).



Toilet area.

Institute *What's your feeling about the number of toilets?*

ADC *It's not enough.*

Institute *How many would you say would be good?*

ADC *Double of what we have...that would be nice.*

Institute *What are your concerns about the shower rooms?*

ADC *Right now two of them are working. There was a big tub (in the third room) and we took it out because it was one of those electronic-type tubs. We are going to put two showers in there.*

Institute *In one room?*

ADC *Yes, because we don't have enough showers either. We're replacing the tub because it doesn't work, it's very costly and the room is big enough that you could put two showers in, plus we don't have enough space. We only have two showers and we need a minimum of four.*

Institute *Will you use two at a time?*

ADC *We are going to put a curtain in there and build it for privacy. Our intent is to have two women in there at a time with some privacy.*

Institute *Are there issues in terms of not enough space in the personal care area to get people ready for a shower and then dressed afterward?*

ADC *It's all tight.*

Institute *You do laundry in that area also. How many people do you do laundry for in a week or day?*

ADC *We average three loads a day washing bibs and towels and doing some of the participants' laundry.*

Wandering and elopement

To date, wandering and elopement have not been issues at Elder Care. Director Thornburg cites the second floor location, staff alertness and alarm system as important security measures. Known wanderers (currently two of a total enrollment of 96) are outfitted with a bracelet-type code alert band. Electronic sentries are located at both elevators as well as front and back stairways. More typically however, staff simply redirect wanderers to the primary program space.

Institute *We really didn't observe many at all, but I know that your activity director said you do have some wanderers.*

ADC *We do have a few, maybe one a day or so, but not so many or to the degree that it's a problem.*

Institute *How often does an alarm go off in a week would you say?*

ADC *If it goes off once a month we're lucky. I know when (we) first opened three or four years ago, the participants were fairly healthy. I think in this last year we've seen a lot of deterioration in the participants. Our participants now are just starting to even get more feeble than what they were when they came a few years ago. So we've been really fortunate that we've only had a couple of wanderers.*

Institute *We didn't see anything like a wandering path at all. Is that something you think about or consider?*

ADC *Not really. I think that if and when we get to that level of participant, we're going to need a different building.*

Advice For Other Providers

Institute *Do you have some thoughts you'd like to share, things you've learned over time with this facility?*

ADC *Never put a day center up on the second floor. Never, even if it's cheap. Be methodical in preparing for growth, and put together a plan that looks five years ahead to where you're going to be and the space you're going to need. That level of infrastructure and planning never took place here. So the program's already outgrown itself by the time we became fully staffed. Make sure you have that organizational conversation of where you're going to be in the future and what you want to look like before you go out and buy the building.*

If you're going to do an adult day center be sure to look at the levels of care that you're going to have in your building, and whether and how you're going to address their needs. (At some point you have to say), "This is the level of needs that I'm going to take, and only to this level." You need to be methodical in your service and not try to be everything to everybody if your building won't allow you to.

Louis Feinstein Alzheimer's Center
Cranston, RI

Theme
How do you take your coffee?

What this case study shows:
· How a collection of meaningfully different spaces successfully accommodate a variety of concurrent activities.
· The value of visual connections: from room to room, from inside to outside.

Place Profile

Director
Cynthia Conant-Arp

Site/context
The Feinstein Center is located in Cranston, a middle-class suburb of Providence, Rhode Island. The center is sited on 19 wooded acres overlooking Brayton Park, a city park with a baseball field, running course and wooded areas. The site is just off a major thoroughfare with easy access to the interstate system.

Facility type
Purpose built facility

Building size
Approximately 6,500 square feet

Construction completed
1995

Architect/designer
Robinson Design, Smithfield, RI

Program

Mission and goals

The mission of the Louis Feinstein Alzheimer's Center is to fulfill the needs of those with Alzheimer's disease and to do so in a way that optimizes each person's independence and dignity. This attitude is evidenced by the Center's "Participant Bill of Rights," which pledges that day care participants:

· Be treated with respect, dignity, and compassion
· Experience a safe, secure, clean and home-like environment
· Have the right to privacy

This focus on the dignity of the participant influences the way in which the Center's mission is realized. Care staff begin by focusing on each individual's existing abilities, emphasizing strengths to enhance each person's self-confidence. The philosophy is not to simply meet the need, but to challenge and stimulate each participant according to his or her abilities.

General description

The program at the Feinstein Center operates Monday through Saturday. All participants suffer from some form of cognitive impairment. There are five primary program areas--the family/living room, dining area with breakfast bar, breakfast nook, den and occupational therapy (OT) kitchen. Most activities take place either in the dining area or the family/living room. Participants begin their days with coffee at the breakfast bar, then proceed to the family/living room for cognitive and physical exercises around 10:30 a.m. Days at the Feinstein Center are planned around three activity blocks (one in the a.m. and two in the afternoon) during which four to six different activities run concurrently. Director Cynthia Conant-Arp discusses the program strategy:

ADC 1 *(In addition to the) three activity blocks, there are activities that happen throughout the day that aren't part of that formal block. The blocks of time are all preassigned both in terms of staff and participants. The more informal activities happen throughout the day, and at the very end of the day often the activity may be a couple of the CNAs leading a sing-a-long or a group doing some reminiscing, or a game, or a trivia group, or looking at photographs of old movie stars.*

Services offered at the Louis Feinstein Alzheimer's Center include

- breakfast, and a hot noontime meal (feeding assistance as needed);
- arts and crafts
- games
- dancing and sing-along
- physical exercise
- reminiscence
- pet therapy
- showers
- toileting assistance
- medical services (i.e., medicine distribution, podiatry, skilled nursing)
- social services (i.e., participant assessment, family support, financial support)

Full fee charges are $56 per day. State assignment and sliding fee scale charges range from $35-48.

Staffing

The Feinstein Center has 21 staff members (FTE total of 16.5). With an average daily census of 45, the typical staff to participant ratio is approximately 1:3.5. This ratio varies through the course of the day and affects the choreography of the program. When census level is lowest (early morning and late afternoon), the number of staff is reduced accordingly and with that, fewer spaces and activities are engaged. Staff are predominately female with nursing training (four are registered nurses and nine are certified nursing assistants). Eight staff members are administrative; 15 are primary care staff. Nine of the 21 staff members have been with the center since its opening in 1995.

ADC 1

We don't use agency people at all. They really can't be very helpful. The staff comes to us because they are interested in the concept of adult day care. Certainly the nurses find a community-based program helpful in meeting with the needs of their own personal lives, especially if they have young children because it's more conducive to their lifestyle. The nurses usually also enjoy being more person-oriented than task-oriented...I can't tell you how often that's cited as a reason for looking for a new job. They have felt that with the pressures of health care today they're not able to provide the kind of quality care that they want to and which this community-based setting allows them. So our nurses have come with broad backgrounds. Many have worked in either home care agencies, nursing homes or in hospitals, in some cases all of them. We recently hired a nurse who'd been working for a long time in the orthopedic ward of a very large hospital and came to us as a volunteer because she wanted to know that there was another way to do things. We hired her after the volunteer experience.

Our certified nursing assistants come from a wide variety of backgrounds too. We just hired three out of a hospital inpatient program that was being downsized. In almost all cases the people we hire have had geriatric experience in the past. In a very few cases we'll hire brand new people who've just received certification. In some ways that's good too, because they bring the high energy and we're able to train them according to our philosophy of care.
To return to the per diem issue, we believe it's terribly important to have consistent staffing. There are times when people are sick and we need an extra set of hands. But we make certain that every per diem gets some advance training so that they know us, and at least their face is familiar to other staff and participants before they actually are engaged to work for a day.

Participant profile

The Feinstein Alzheimer's Center has 85 enrolled participants, a self-imposed maximum daily census of 50 participants and an average daily census of 45. The Center serves 23 Rhode Island communities, in effect, most of the state. Conant-Arp talks about the program's appeal with additional comments offered by social services team member Ellen Grizzetti:

ADC 1

We're centrally located, which makes it very helpful in recruiting participants, where some of the other centers are quite remote. But transportation is an issue. A lot of centers provide their own transportation in addition to relying on the Paratransit (state-operated) program. We haven't needed to yet, and I hope we never do.

Because we have the space and the capacity to run multiple activities at once, we can really focus on the individual. We have the ability to make an early Alzheimer's victim a star--more like a volunteer here. That makes for a nice transition to the program. We may buddy them up with someone who needs support, or with a peer if they're demonstrating some resistant behavior, not wanting to come to the center. We bill ourselves as the facility for Alzheimer's and we will do all we can to support

your loved one for the long haul. When we talk to families we try to approach it by saying that we will help you according to the level of your need, and we're there for as long as you need us. In most cases we're there until very near the end, sometimes to the end.

Institute *Was that a philosophical position you began with, or has it simply evolved as your participants needed more?*

ADC 1 *I think we began with it and it's strengthened as we have evolved as an organization. For example, when some of our people became medically intensive there was some discussion: Is it appropriate to direct that much staff time to help one individual? I think we've come pretty much to the consensus that, yes, it is appropriate until such time as the family is ready for the next transition. It's our responsibility to provide the support and the education to effect that transition. Sometimes we have to just push things a little bit, though not often. Sometimes we need to get family in and sit down and have a heart-to-heart. It's when we feel like our staff are at risk of injury and that kind of a thing. That's really what pushes us over the edge usually.*

ADC 2 *I can tell you that we've been pressured on several occasions to introduce geri-chairs for more advanced participants.*

Institute *Pushed by?*

ADC 1 *By caregivers, some physicians as well...at this point our staff is really uncomfortable with the idea, because we feel it makes us more of an institution. It's not a clear-cut issue, because we also want to help families, and not having them limits the amount of help we can provide to the very advanced cases. On the other hand, we have to think about the comfort of the larger group. I don't know that we've come to any firm resolution, but for now we've reached consensus that we prefer hominess to the institutional flavor that we believe geri-chairs would introduce.*

Participants are as young as 56 years, with an average age of 82. The gender ratio is one male to two female. Ninety-two percent of participants are white; approximately four percent are African American and five percent are Hispanic. All of the participants have a diagnosis of Alzheimer's or a related disorder. Fifty percent of participants require some form of mobility assistance and 16 percent use wheelchairs. Fifty-nine percent are incontinent, and 42 percent are dependent in three or more activities of daily living. The intake process uses a "get-acquainted approach" strategically:

ADC 2 *Things get started when we receive a signed form from the physician...then we invite the family in, together with social services and the RN...we go over all of our policies and procedures to kind of get an initial picture of the participant. While we're having that meeting with the family, the person is introduced to center activity, kind of a little orientation period. They feel more reassured that "I don't stay here, I go home, there aren't any beds here," that kind of thing. We do some one-on-one and draw on whatever ability he or she has to remember being here by making sure*

that the same staff person will be here on their next visit to the center, which will be for the full day. We really don't do a half-day thing. Probably during the first week of attendance we'll do an assessment of the participant.

Institute *Do you ever turn people away?*

ADC 1 *Everybody gets a chance, even if we are very skeptical about the likelihood of their success in the program. We believe that everyone deserves a try.*

ADC 2 *But we do have a two-week assessment period agreement that we ask families to sign on admission; the time period is actually shorter than that if necessary. It kind of protects us if somebody really is extremely difficult.*

ADC 1 *...or had inappropriate behavior. We have had a couple occasions where there was overt sexual behaviors or overt aggression. Even in the cases when we discharge, we suggest alternatives and ways in which the problems might be remediated so that there's some chance to come back and try again.*

Institute *What's your success rate when people walk in to stay?*

ADC 1 *It's extremely high. If we get them through the door to actually see the facility during the day care day, it's close to 100% conversion rate.*

ADC 2 *It's very rare that we have people claiming: "My loved one isn't happy here." You know, if the caregiver is on board, you're 90% there. With a reluctant caregiver, forget it. If the primary caregiver won't encourage that person in the morning and get them on the bus, it will never work.*

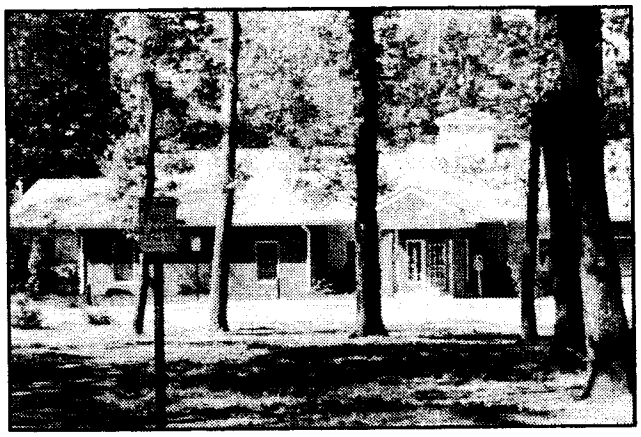
ADC 1 *Sometimes the individuals who come to us have been homebound for so long, and the caregiver has completely wrapped his or her identity around that person... it's very hard to assess that separation. It's highly individualized. In those cases, the relationship will be redefined. What we try to do is help the caregivers enjoy a new quality of the relationship with less task orientation.*

Institute *It's a process of reconstruction.*

ADC 1 *Right. Many times people come to us "incontinent" and "unable to feed themselves," when all that's needed are some reminders, some cueing and an environment that's conducive to maximizing ability.*

ADC 2 *"She used to be a great cook, but she can't do that anymore." "She used to do needlework all the time." We hear those kinds of comments because you know it's your mother and you want her to be all she was. We just know them for today, so we rely on what they're still able to do. People walk away feeling good about themselves again.*

Physical Setting



Exterior of the Feinstein Center.

The welcoming reception area.

The Feinstein Center is situated on 19 acres of city-owned parkland. By car, one approaches via an extended, winding route: a makeshift directional sign placed at a crossroads is intended to eliminate wrong turns. Parking spaces are placed toward the outside of the loop, away from pedestrian travel, and spaces are grouped in clusters of six or less.

Participants are dropped off under a canopy that extends from the airlock vestibule. The airlock has windows on both sides, which provide light and a sense of spaciousness. From the airlock, one enters the foyer, outfitted with French Provincial-style furnishings. To the right is a small sitting area with two chairs and an end table. To the left is a library table with participant nametags, brochures and guest book. At the far end of the foyer is a stylish mahogany reception desk. Behind the desk is a six-paned interior window that provides a view into the main program space. Walls are white-painted drywall with wood detailing. The floor is carpeted.

To the left of the foyer is a personal care area, which provides storage for participants' personal items (i.e. a change of clothes); this area is accessible also from the shower room. To the right of the foyer are staff areas, including a social work office (originally intended as maintenance space), nurse's offices and staff work/breakroom. These spaces all have plain wall finishes and acoustical tile ceilings.

A solid paneled door leads from the foyer into the primary program space. Once inside, one encounters the "U" shaped breakfast bar, constructed of deep green laminate. Windsor-style wood chairs are spaced around its perimeter.

The breakfast bar projects into the dining area, a large space that serves for dining as well as large group events. Two large skylights admit ample natural light. An expansive window wall faces southeast and looks out onto a tidy patio garden. Interior walls have windows (also termed "vision panels") that provide views into adjacent rooms. Recessed incandescent light fixtures and sconces supplement natural light. The ceiling is acoustical tile. The walls feature vinyl wallpaper and ceiling border trim and a wood chair rail. Flooring is wood-look vinyl.

Storage adjacent to both entry and personal care area.

The wall between the dining area and the family/living room features two sets of wood and glass french doors. This architectural device allows visual connection and provides a means of privacy and sound control between the two rooms when the doors are closed and the blinds are drawn. The family/living room is an irregularly shaped room consisting of a large main space and alcove. The furniture in the living/family room is institutional (vinyl seats and backs with wood arms), and typically arranged with two long tables placed end to end to the north and a circle of chairs (such as for discussion) set up facing the alcove but extending well into the main space. The arrangement results in part due to an accordion door at the midpoint of the room. While the alcove was originally intended as the location for the activities director's desk, its placement in the open prompted rummaging behavior and has since been removed. The room has carpeting, white walls and an acoustical tile ceiling. An exterior door provides access to a patio area oriented for morning sun.

Family/ living room.

A wandering path surrounds the service pantry. Located along this path are the occupational therapy (OT) kitchen and its adjacent breakfast nook. Both rooms are residential in feel, with areas for cooking and baking as well as mealtime assistance. The OT kitchen has upper and lower cabinets with undercabinet lighting and a counter for OT therapy. There is a

An alcove creates a semi-private space.

The service pantry.

refrigerator, stove and kitchen sink with a window above. The breakfast nook has a service window detailed like a residential breakfast bar. Windows on two sides help create a feel for the breakfast nook that is light and airy. The room is painted white and has vinyl sheet flooring.

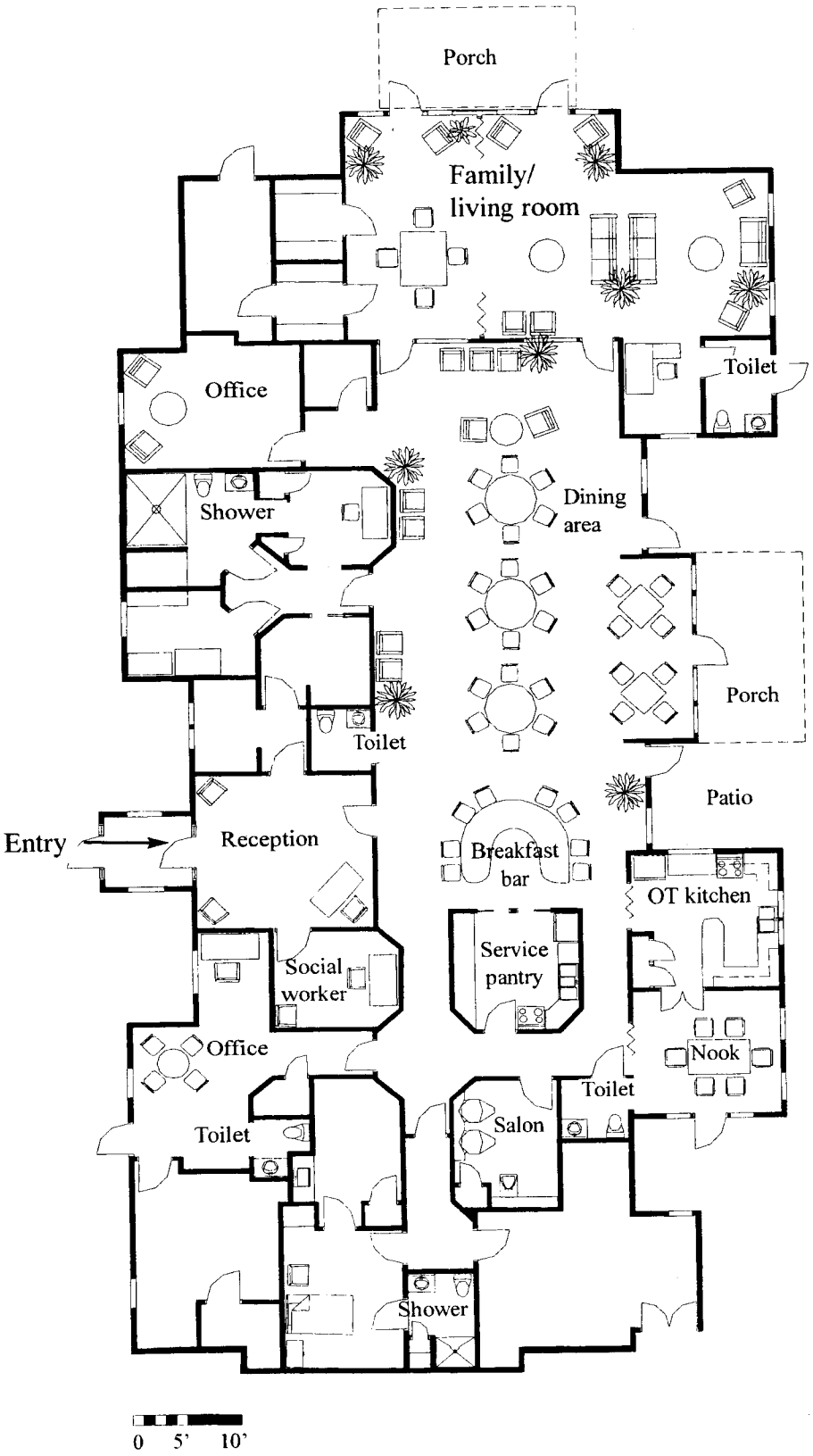
Behind the breakfast bar is the service pantry in which kitchen activity is conducted and meals are plated by staff. In use, the pantry has proven to be a rather cramped space, evidenced most at lunchtime. However, its spatial relationship to the breakfast bar and the aromas that are produced as a result of kitchen activity are strong positives of the scheme.

While there are five toilet rooms with a total of five fixtures scattered throughout the facility, two rooms are somewhat remote from the most used program spaces. Thus in effect, there are three toilets serving 45 participants per day. Further complicating things is the fact that two toilets are located in shower rooms; when showers are occupied, these toilets are unavailable for privacy's sake.

The Feinstein Center has no tubs, rather, participants are bathed in showers. The assisted shower room has ceramic tile on the walls and floor. A second shower room stands idle as it requires independent use.

Ancillary spaces consist of a room for medical visitations, respite and therapies as well as a beauty salon. The secure outdoor space consists of a treed area with planting beds and a wandering loop overlooking Brayton Park. While the area is secured only by a wooden picket fence 4½' high, elopement has not been a problem.

Floor Plan: Feinstein



Coming and going

Dropped off by van or family members, participants begin to arrive at the Feinstein Center as early as 7:00 a.m., though the majority arrives between 8:30 and 9:30. Passing through the main door, one is welcomed by the sight of the breakfast bar. Staff are quick to meet newcomers and involve other participants in greeting arrivals.

Institute *I know Rhode Island is small, but coming from all over the state means some substantial travel times. What's the maximum travel time for participants?*

ADC 1 *We participate in the statewide Paratransit System as well as the Americans with Disabilities Act Transportation System. There are some families who choose to transport privately. In one case we even had a lady who arrived and departed in a limousine. They were paying $100 a day for transportation and only $50 to attend day care! The Ride Program aims for no more than one hour on a bus, and I think for the most part they're successful. For other facilities I've known transport time can be as long as two hours each way. That definitely would be problematic for the population we serve.... Under an hour generally is manageable, and we do plan for some ADL assistance right before bus time.*

Departures have a different character. While arrival is associated with a sense of relief and destination, departure is anxious. Participants are more likely to be agitated by late afternoon and tend to gather by the exit door near the breakfast bar. For some, the anticipation of leaving may last for several hours. They sit at the breakfast bar or turn chairs in the dining area to face the door. This situation, which raises the stress levels of all present, is caused by the inevitable fatigue and associated anxiety that results from activity of the day.

Institute *With the census a third larger than you initially anticipated, how do things work in the morning coming and going, people arriving and taking off their coats, boots...?*

ADC 1 *We usually assign one person to that front door.*

Institute *Does it usually get a bit jammed up or are you able to space arrivals?*

ADC 1 *It can, but I think we have enough staff that it's never a source of frustration. In the afternoon I think it's a little bit more problematic, because most of the busses come between quarter of four and quarter past four.*

ADC 2 *And the anxiety level is just a tad higher.*

Institute *How do you manage it?*

ADC 1 *A couple of ways: we try to keep folks in activity for as long as possible, because downtime is when anxiety really starts to gel. We don't bring coats out onto the floor. As the bus arrives, they come in with a list of names of who they're collecting, and one staff person goes out onto the floor to gather those folks.*

Institute *Do busses typically arrive in the same order?*

ADC 1 *No, but the drivers know to line up and they know that only one bus will be loaded at a time. We're very adamant about that. We're just as careful as we can be. It works pretty much without a glitch, but our folks get anxious that time of day. Seven hours is a long time.*

Primary Program Space

Activities at Feinstein take place in five different areas but are concentrated in three: the dining area, the breakfast bar and the family/living room. The presence of multiple spaces not only permits concurrent activities but maximizes uses of the setting.

Family/living area.

Early in the morning, participants arrive and have breakfast at the breakfast bar, the first "activity" destination. After breakfast participants proceed naturally from the breakfast bar to the family/living area, where they engage in a cognitive activity. Large group events take place in the dining area, the largest space in the facility.

ADC 1 *Most days, following breakfast we have our first activity block of the day, usually around 10:30 and we go into about five different activities. Some are for our earlier stage folks, others are for people interested in crafting, outdoor folks that want to walk, that sort of thing. There are usually five or six different things going on. On Mondays, though, we have a wonderful entertainer who comes in. He plays the guitar and sings--he's great with our folks. They get up, they sing, they dance, they do it all. In that case, it's really impossible to have more than one activity because, although we like smaller groups, the music just draws everybody in. He has the undivided attention of our folks.*

ADC 2 *I was going to say that there are a few people who don't handle that stimulus well. You'll see two or three stragglers back in the living room who won't join in, but for the most part everyone is engaged.*

ADC 1 *Right, the volume can overwhelm them. But while it's happening--they're engaged and you don't need as many people on the floor--our nurses take the opportunity to do personal care. So, Monday mornings are a great time to get a lot of showers done; they generally do four or five during that activity time. Bathrooming happens then, too. When Lou (the musician) wraps it up at around quarter to twelve, we do our bathrooming for lunch, and then everyone is transitioned to the dining space.*

Afternoons, four groups are run concurrently. The French doors and interior windows allow participants to visually sample and choose among activities; vicarious participation is permitted as well. The alcoves and niches throughout the facility afford more intimate discussions and/or limited involvement in the main activity of the space. Similarly, the outdoor area can be used as a more private sanctuary, with participants taking time out for a breath of fresh air.

The OT kitchen.

Kitchen and kitchen work

No kitchen work as therapeutic activity was observed. However, the occupational therapy kitchen appears reasonably laid out, providing enough workspace and access for participants to participate in meaningful baking activities.

By contrast, the service pantry (behind the breakfast bar) has proved too small a space for efficiently serving lunch to 45 participants. With two staff plating meals and one checking trays to ensure dietary restrictions are met, service bottlenecked at one side of the breakfast bar with three or four staff waiting to serve trays.

View of the dining area.

Dining

A large group activity is held in the dining area just before lunch, so the dining experience begins with staff and participants repositioning tables and chairs for lunch. Often, it is participants who are first to begin the rearranging, in effect, creating a meaningful activity that exercises functional abilities.

At the Feinstein Center, participants have four options for dining: in the dining area; at the breakfast bar; at the counter of the OT kitchen; and in the breakfast nook. In the dining area there are two table sizes: square tables for four

people and a few two-person round tables. The breakfast bar offers seating for eight at a counter where staff can assist participants. The OT kitchen counter provides a location for those who enjoy kitchen ambience or desire separation from the stimulation of the larger room. Finally, the breakfast nook offers a sunny yet private environment for participants who need assistance with eating.

The breakfast nook located outside the OT kitchen.

Given dietary restrictions and the fact that trays must be assembled individually, efficient service can be a challenge. It was not uncommon to see one person at a four-person table served lunch 10 minutes before their tablemates received meals.

ADC 1 *Usually people have a "regular" table that they sit with and it's sort of their choice, kind of the way friendships develop in any age group. That works out well. The nurses always oversee the lunch. They change the texture of the food for the people who need it, keep an eye on table settings and so on. Some of our folks are served in the back kitchen area and some in the main dining room.*

Institute *How do you differentiate?*

ADC 1 *It's usually people who require more assistance with feeding, or if we get the sense that the noise level is too much for them. Everybody pretty much starts in the large dining room, we go from there. If we feel it's not working, perhaps they're just not eating well and we don't know the reason, we've tried less utensils, tried assistance and nothing seems to be working, then we'll try that quiet space.*

ADC 2 *We also have some people seated at the breakfast bar, primarily folks who have problems with swallowing. The nurses use the breakfast bar as a mini nursing station at lunchtime, and the great thing is, it doesn't look institutional. So they're able to supervise right there.*

Institute *Yes, the breakfast bar seems to be a wonderfully elegant way of solving the need for the typical U-shaped table, where everyone knows what it's there for and why it's there. This does all the same things, but it's absent the stigma.*

ADC 1 *We love that. It's a great place for activities in the afternoon too. They've squeezed their own lemonade there, and had a lot of cooking groups. Even a small bingo might get called there or a sing-a-long or whatever. It's great.*

Toileting

The Feinstein Center has five toilet rooms with a total of five fixtures, though two rooms are somewhat remote from the actively used program spaces. Thus in effect, there are three toilets serving 45 participants per day. This would not be enough if it were not for the Center's toileting program of regularly scheduled "potty visits." The execution of this schedule is illustrated by staff engaging participants in an activity (such as dancing during a music presentation) and simply moving the activity toward the toilet. Participant dignity is retained, stigmatization reduced, and potential interruptions to group-programmed activities minimized.

Institute *It seems that lots of day care providers face a problem of bathrooms five or seven years later. The bathrooms they built weren't spacious enough to accommodate a two-person transfer and things of that sort. How has this been for you?*

ADC 1 *Yes, we had that frustration (in our former facility), so we made sure the architect understood, and now we really don't have that problem here.*

ADC 2 *We've even done the occasional three-person assist, but there we had to look at the benefit to participant and benefit to program of doing three-person assists...*

Institute *That's pushing the risk?*

ADC 2 *Yes, that's pushing the risk to staff. Now we're faced with the question of, "Is this time for a Hoyer lift?" It's really not appropriate in this setting. It's one of the discharges we've had to effect.*

Showering

The Feinstein Center does not offer baths but does give three to four showers daily. Although there are two shower fixtures available, the independent shower stall goes unused. Of note is the fact that the architect made allowances in one of the shower rooms for the future installation of a tub. The decision process is recounted here by the architect, John Robinson:

Architect *What had happened was we couldn't decide if we should have a side entry tub or not. So we agreed to design a space for a shower and leave enough room so that if later on we want to bring one in and try it out the space would be available. So that's why we have this long shower. That electrical plate is there for the eventual/possible...*

Institute *You haven't felt the need for a tub to date?*

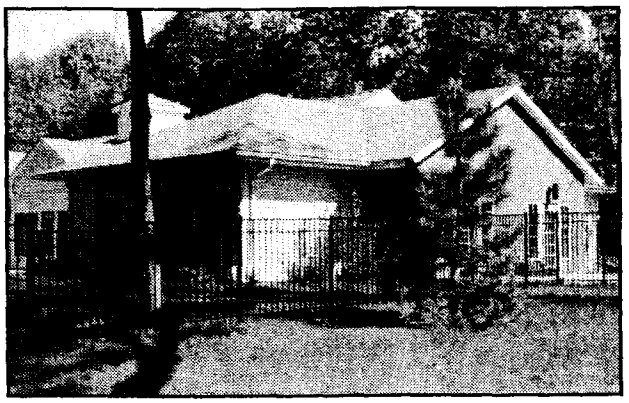
ADC 1 *No, and actually after talking with colleagues and nursing homes, they expressed their concern about side-entry tubs and Alzheimer patients. The patient has to get into the tub before it's filled and there's a lot of noise associated with filling the tub. At least from my colleague's perspective, it was a very frightening process.*

Wandering

Not much wandering was witnessed at the Louis Feinstein Alzheimer's Center. Perhaps the number of environmental choices available fosters enough diversion to reduce the pacing associated with agitation. Also, in the course of activity programming there is a great deal of movement between rooms, an integration of physical exercise that allows participants to release energy through the normal progression of the day.

Outdoor space

With access to nature all around, the Feinstein Center sits on a 19-acre site overlooking a city park. While not fully developed, the outdoor space does provide a wandering loop and some opportunities for engagement (e.g. a raised planting bed). As important as the ease of accessing the out-of-doors for a moment of solitude or for the opportunity to maximize functional abilities is the visual access provided to the outdoors throughout the facility.



Secure outdoor garden area.

ADC 1 *We just started our pretty season here, but if you could see this in the fall, it is magnificent. We've had ponies in the backyard, we've had a carnival in the backyard and it's been wonderful. I know it's very small, but it's spacious enough for the census that we're serving.*

I think that one of the major problems encountered by adult day programs for dementia is that in creating the margin of safety and finding an affordable solution, they often neglect the outdoor spaces, and I really feel that's a big part of our success here. Even for those who aren't actively able to enjoy the outdoors, the outdoors is brought to them through the use of glass. Perhaps that's an oversimplification, but I really do think it's critical to our success.

(Case in point regarding the outdoor space) is one of our participants. This woman firmly believes she's the president of the garden club here. Now we believe in reaping what we sow, and integrating those situations into our programs. It's really been very beneficial. It's our responsibility to reach the person trapped inside. Sometimes the vehicle may be gardening, sometimes music or art, it may be reminiscence. No matter, in some way we have to reach those individuals, and it's nice to have the resources to be able to offer the alternatives.

Advice For Other Providers

ADC 1 *I would love to be part of a senior campus. Not necessarily a senior campus, but a campus that allowed people the sense of community that's so important especially to our elders. A place where there's an opportunity for independent living, an opportunity for assisted living, an opportunity to receive some services within a private home-like environment, an opportunity to benefit from the services of an adult day center, where there's a community center in which folks can participate. I'd like to think that someday there'll be not necessarily one-stop shopping, but at least there'll be a range of services within the same community setting and I would love to see that happen.*

Institute *Is the goal that such a campus not be located on its own 40 acres isolated from the rest of the world, but truly knit into the community?*

ADC 1 *Right, but at the same time it needs to have enough of a physical environment, an exterior physical environment. It's a park-like setting like this that's pastoral and where people actively interact with the physical environment that's so important in our facility here. It's a key to who we are as well, because it creates the sense of freedom here, not entrapment.*

Architect *One of the greatest things you see here is what a positive impact this facility has had on some people's lives, some families. At the facility's one-year anniversary, there were a few different couples giving testament, but one couple recounted the story of how difficult their lives were. The emphasis was on turmoil: their lives were in such turmoil and depression, and within a year of arriving here, everything had changed. It was tremendous. It's not just the architecture obviously...*

ADC 1 *No, but the architecture makes that possible. I really think that the people and the architecture work together. If I define quality in adult day center, I'd have to define environment, communication skills with staff, organizational philosophy and the capacity to do behavioral interventions with the caregiver, the care provider, and our staff. It's about changing behavior in order to effect a change*

Architect *I've seen in other facilities and nursing homes for the elderly that were designed wonderfully, but they just didn't have the commitment. Things get tough, and the next thing you know administration reacts by locking doors....*

Luther Manor Adult Day Care Center
Milwaukee, WI

Theme
Introducing options.

What this case study shows:
- The advantages and challenges posed by separate program spaces.
- How a well-planned functional program can give way to emerging use opportunities.

Place Profile

Director
Beth Meyer-Arnold

Facility type
Purpose built. Part of a large continuum of care campus, the adult day center is a physical link between the assisted living and skilled care building, and rehabilitative clinic.

Site/context
Luther Manor's continuum of care campus occupies a multi-acre site on Milwaukee's northwest side. The neighborhood surrounding Luther Manor is low to middle income, consisting mostly of small single family homes, duplexes and apartments.

Building size
Approximately 10,500 square feet

Construction completed
1990

Architect/designer
Architecture 2000, Milwaukee, WI

Program

Mission and goals

As a ministry of United Lutheran Program for the Aging, a non-profit association of more than 70 Lutheran congregations in the Greater Milwaukee area, Luther Manor's extensive scope of services makes real its explicit mission, which aims to provide "a comprehensive and compassionate program of excellent housing, care and services contributing to the wholeness of body, mind and spirit" to older adults of all faiths. The goal of the adult day care in particular is to maximize the independence of seniors whose physical and mental conditions interfere with their abilities to live independently, and to assist them in remaining in their homes and community.

Given these conditions, Luther Manor Adult Day Care Center has a range of program and service objectives. Key service objectives include providing access to comprehensive medical, social and health support services, serving nutritious meals, and assisting with personal care activities. Priority program objectives include providing a multidisciplinary team to develop a plan of care for each participant, dementia-specific programming, and offering a structured, goal-oriented program of therapeutic activities.

Institute *You describe Luther Manor's adult day center program as a nursing-based model in contrast to a social service or activities model. What do you see as the differences?*

ADC *To me, a nurse-based model means a more holistic plan of care. In other words, the plan of care not only focuses on the person's interaction, their socialization abilities, whether they've been isolated at home and if this kind of a group setting is going to help that isolation, but also considers the person's health--mind and body health. It means that we can provide medical support services, like dispensing medicine, checking blood levels and the like. In addition, this nurse-based model means that we can help families access all the other aging network systems that they might need over time.*

Institute *And what does the social service model focus on?*

ADC *Social service is only a piece of the health model. I think social service is integral to what we're doing. It's activities and activities are good for people. Socializing, eating a meal together, respite for the caregiver, those are all very good things. On the other hand, what I've seen with day cares that say they are a social model often means that they don't have a nurse on staff, so they're not able to do things like assist with medications or help families with health-related things. What that comes down to is that people with complicated issues can't get the care they need. People with dementia, or people with physical needs or difficult medical conditions, for example, tube feeding or an unusual diet; many of those things can't be addressed.*

Institute *How do the goals of the two models differ?*

ADC *I see both models as helping families keep people independent and living in the community, but I believe that the medical and nursing health model (because I'm a nurse I'm more apt to highlight the value of the nursing piece) of day care may help families wrap services around so there may be fewer stops (along the continuum of care). With the social model there comes a point when the program doesn't have the capabilities to help any longer, and then they must help families make the move to a group or nursing home. Our goal in Luther Manor's program is to help eliminate some of the middle steps so families can continue to keep people in their homes longer.*

General description

The program at Luther Manor takes place in two spaces, the Great Room and the Skylight Room. The original program specified that the majority of Luther Manor's participants would utilize the Great Room. Those suffering from Alzheimer's would be cared for in the Skylight Room, which would be more specifically therapeutic for a dementia population.

Nearly a decade later, both rooms are fully utilized by the program, though not in the diagnostically-related manner originally intended. The decision to place a participant in one of the two rooms is based on how the individual responds to day care. Having a choice of two environments has proved invaluable:

ADC *The participants in the Skylight Room are people who definitely do better in a smaller group. They are unable to handle all the choices in the Great Room; most are overwhelmed by the noise, distraction and too many opportunities. By minimizing all of that we can help them have a more successful day. Many times it is because of their cognitive deficits. Some times it isn't, sometimes it's because of physical limitations. We have people in the Great Room who have lower scores on their Mini Mental, so you could describe their dementia as more advanced or their cognition as more impaired, but they handle distractions better. Actually, sometimes those participants need more things to keep them occupied or a bigger space to walk around in. On the other hand, some people with very impaired cognition become paranoid in the Skylight Room because it's smaller. For them, the Great Room is the better situation.*

Luther Manor provides services to its participants and their families from 7:00 a.m. to 5:00 p.m. Monday through Friday. Theoretically, the daily scheduled program for the Great Room and Skylight Room is the same, though staff in the Skylight Room have greater discretion to deviate from planned activities to accommodate the needs and abilities of its participants.

For both rooms, staff conduct a single activity at a time, with the exception of the 9:30 to 10:30 time slot in the Great Room, when two activities are offered. Periods throughout each day reflect a therapeutic orientation (i.e., 9:00 to 9:30 is a large muscle exercise, 9:30 to 10:30 entails a cognitive activity) though activities vary throughout the week. While programmed in advance by the activities director, daily activities are conducted with respect for each day's participants, based on their individual needs. Generally, early morning is deemed "free time" for participants and many watch TV or converse prior to scheduled activity.

While the Great Room and the Skylight Room programs are conducted independently for most of the day, participants are consolidated as one group in the Great Room for the purpose of staffing efficiency during early mornings and late afternoons. In addition, the two groups of participants join together in the Great Room for special events, such as singing.

Services offered on a daily basis at Luther Manor include:

- A hot noontime meal, as well as a morning and afternoon snack.
- Programmed activities (exercise, storytelling, crafts, music)
- Health care (i.e. nursing, dentistry, dermatology, optical, podiatric)
- Personal care (i.e. toileting, bathing, medication)
- Physical/occupational therapy

The full daily rate at Luther Manor is $45; whirlpool baths are $10 for each session.

Staffing

Luther Manor has a full-time staff of 17. Ten have high school educations and six have attended college. One staffer has a master's degree. Almost one-third have had no formal training in gerontology. The ethnically diverse staff ranges in age from 30 to 65; most are women. The salary range is wide among staff: although some administrators earn more than $45,000, most line staff earn $25,000 or less. Of note is Luther Manor's low turnover: average staff tenure is more than five years; eight have been with the program for eight or more years. Some of this management success can be attributed to the organization's cultural philosophy:

ADC *When you're working with women--many of whom are single heads of household--and entry level salaries, the challenge is to empower them, and I see that happening in one of two ways. First, you can remind them of the value of their work and their contribution so that they can stay in one place and have the opportunity to realize some real benefits--pension, vacation, etc. The second way we can help empower is by providing a solid foundation for someone who wants to go back to school or explore another career. Establishing solid employment is empowering.*

Great Room staff to participant ratio varies from 1:6 during lunch to 1:10 at other times. Skylight Room staff to participant ratio is 1:6.

Participant profile

Luther Manor Adult Day Center has 172 enrolled participants with a maximum capacity of 55. The average daily census for the day care is 48. Participants range in age from 53 to 96 years, with an average age of 83. Participant gender ratio is two females to one male. Seventy percent of participants are Caucasian; 30 percent are African American. Ninety percent of participants have some level of cognitive impairment, with 53 percent scoring 17 or less on the Mini-Mental State Exam. Thirty-five percent of participants use wheelchairs. Fifty percent are incontinent, and 57 percent are dependent in three or more activities of daily living.

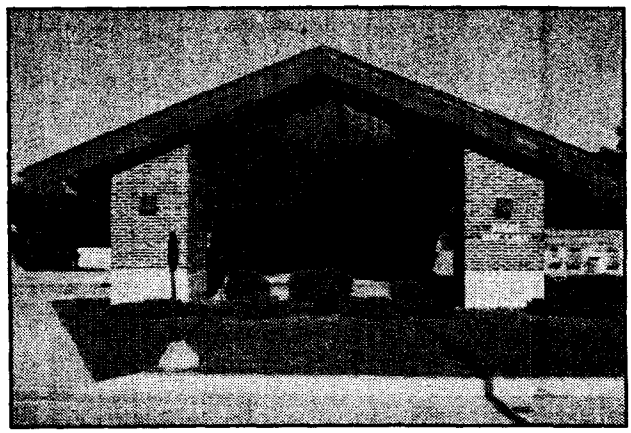
Although Luther Manor is licensed and certified by the State of Wisconsin, Medicaid funding is not a significant revenue generator. Participant fees make up 60 percent of revenue; another 22 percent come from Luther Manor's sponsoring agency. Luther Manor draws its participants from a four to five zip code area that surrounds the campus.

Institute *In your experience of talking with new participants and their families, what would you say is the primary rationale for enrollment?*

ADC *What I hear most often from families is, "My mother or my father needs to be around other people." Then after the interview or a couple of weeks after the interview we find out that they really have been struggling with all sorts of behaviors, from incontinence to declining social skills to needing help with medications and the whole health issue to basic activities of daily living. We may find out that this person hasn't had a shower in months. But the reason we are given is social isolation. Then there are probably 25 percent who say, "My doctor told me I have to do this." Especially when people are feeling guilty, thinking they should be doing all this care by themselves, it helps when the doctors say, "You have to do this. Call me back in two weeks after you've toured a few places and signed up somewhere."*

Physical Setting

The day care facility is a low-profile, single story building roughly rectangular in shape. The exterior is dark brown brick veneer with a shingle roof. The porte cochere has brick piers and is lit by a skylight.



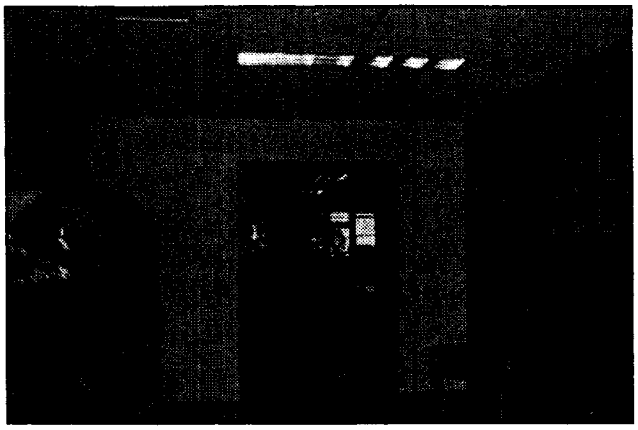
Front facade of Luther Manor.

Program spaces consist of the entry, vestibule/coat room, Great Room, Skylight Room, bathing room, nurse's office/respite room and enclosed patio area. Administrative offices are located to the south of the program areas along the main corridor.

The entry consists of two sets of sliding glass doors separated by a ten-foot airlock. The doors, which operate automatically via electronic motion detectors, open directly onto the main corridor and reception area. The interior color scheme is burgundy and cream with wood and wallpaper accents. The main corridor, lined full-length by a wood handrail, is lit by cove lighting and sconces. Flooring is carpet. The ceiling is primarily gridded acoustical tile with drywall details. The reception area is defined by a blue laminate healthcare counter.

Across the corridor is the main door to the Great Room. The solid wood door (lockable from the inside) opens outward into the main corridor. On the other side of this main door is a vestibule/coat room. Along one side of the vestibule/coat room is a full-length coat rack. This room also features laminate solid-front lockers for storing participants' boots and personal belongings.

From the vestibule/coat room one proceeds into the large and open Great Room. This space is organized into three zones: the kitchen, the central dining/activities area, and the living room. The open residential-style kitchen area has a full-size refrigerator, range, microwave, dishwasher and commercial-style coffee urn. Two walls have light wood-grained laminate upper and lower cabinets.



Storage for coats to left and personal storage to right.

Flooring is vinyl tile; ceiling is inlaid acoustical tile. A unique feature of the kitchen is a rectangular, moveable island, which helps define the kitchen zone spatially from the dining/activities area.

The central dining/activities area of the Great Room measures approximately 900 square feet. Plenty of natural light is admitted through the west wall of windows; a glass door also along this wall allows access to the secure patio area. Underwindow cabinets provide storage. The kitchen's vinyl tile flooring continues throughout the dining/activities area. The ceiling is acoustical tile with drywall detail along the perimeter. Furnishings in the dining/activities area consist of three rectangular and four square tables. Contemporary styled wood chairs have arms and vinyl upholstery.

The dining/activities area abuts the living room area, defined in part by a full-length accordion door and a flooring material change from vinyl to carpet. The west wall is a continuation of windows and cabinets. Overall, the living room area is dark, though the space is fitted with recessed incandescent can lights, sconces and table and floor lamps. The living room has a mix of furnishings including sofas, loveseats, occasional chairs, recliners and end tables. Typically, seating is arranged in a horseshoe-type configuration. An upright piano and turntable/stereo receiver are used for musical entertainment.

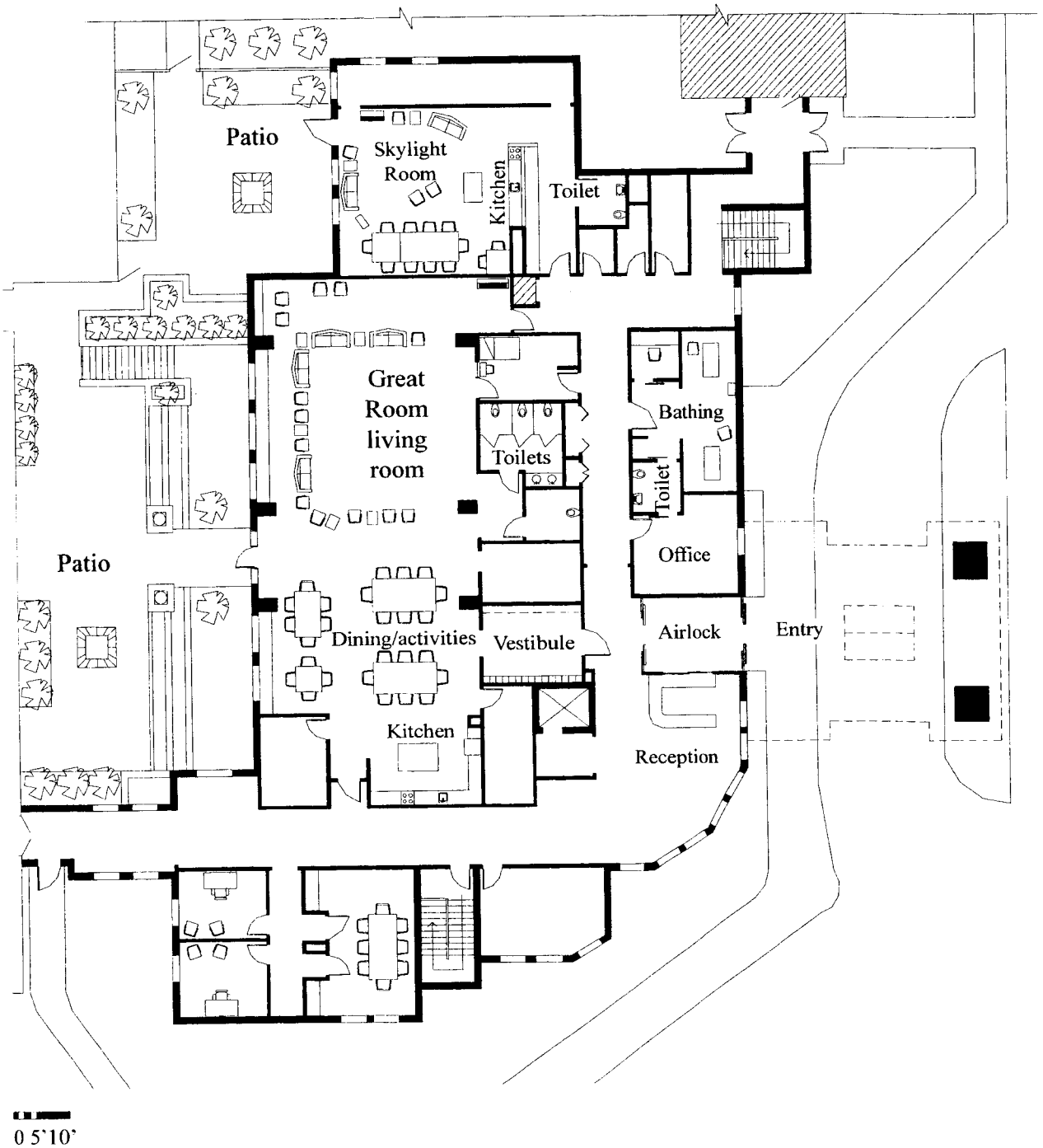
The Great Room has three toilet rooms. One restroom has three ganged toilet stalls, a second is for one-person assisted toileting and the third equipped for two-person assisted toileting. Toilet rooms have ceramic tile floors, walls and fluorescent lighting.

The nurse's office/respite room contains one twin-size bed, computer station and chair, built-in laminate counter/cabinet, and medical equipment storage.

There is one bathing area for the facility, located across the corridor from the day care's program spaces midway between the Great Room and Skylight Room. This ceramic tiled bathing room has a toilet, tub and dressing area.

From the facility's main corridor, a locked door and hallway lead to the separate Skylight Room, substantially smaller than the Great Room. A unique architectural feature is the skylight (hence the room's name) located above the galley-style kitchen. The Skylight Room's multi-purpose area is centered around one large rectangular dining/activities table. The adjacent living area consists of recliners, end tables and sofa. A glass patio door opens onto a courtyard that connects to the Great Room's secured patio area. An area intended to facilitate pacing is defined by a drywall partition at the north end of the room. The Skylight Room has one toilet, a conventional one-person bathroom located along its entry hall.

Floor Plan: Luther Manor



Coming and going

Dropped off by van or family members, participants begin to arrive at Luther Manor as early as 7:00 a.m., though the majority arrives between 8:30 and 9:30. Luther Manor has a covered entry, yet due to transit company regulations that prohibit them from entering under canopies of less than a specific height, many van drivers drop their participants off well ahead of the covered entry (porte cochere), which makes for a longer walk to the day care entrance and less shelter from natural elements.

Entry to the facility is through the two sets of sliding glass doors separated by an airlock. Passing through the second set of doors, each participant is greeted in the building's main corridor by the person sitting at the reception station. This corridor sees heavy use as the primary thoroughfare for the day care program as well as between buildings (apartments, day care, health clinic), and between day care administration, bathing, the great room and the skylight room.

Across the corridor is the main door to the Great Room. This door is heavy, solid and swings out into the main corridor. Passing through the main door into the vestibule/coat room, staff assist participants in removing and hanging coats, hats, gloves and boots and overshoes in winter. If participants need to sit during this process, they are seated in the dining room.

Institute *When there are two or three people arriving at one time, some of the coat removal ends up happening in the dining area (inside the great room). Do you think the coat room should be larger or is it okay that coat removal happens in the dining area?*

ADC *It's okay. I'd rather it not happen, but there just isn't enough room in the coat room. I wouldn't want to give up any program space for a larger coat area, but we certainly have run out of coat room. I am just amazed. We are trying to figure out if we can eliminate the storage cubes on either sides of the coats and extend the hanging pole. Now that we have 50 people, there isn't enough room for 50 winter coats. We're hanging the overflow in the Skylight Room now. Related is our need of storage space for wheelchairs. Many of our participants arrive in wheelchairs, but they can get out of their chairs while they're here. When they leave them in the coat room, then the space gets jammed up.*

Institute *Are there more wheelchair-assisted participants than you thought you'd have?*

ADC *Oh yes. And that doesn't reflect the people who sometimes use them, or who need them after they begin our program, that sort of thing.*

Departures share many of the same characteristics as arrivals. The first departures of participants from both the Great Room and the Skylight Room begin around 3:00 p.m. As the census of the Skylight Room dwindles, the groups are gathered together in the Great Room. Most of Luther Manor's participants depart for the day from the Great Room.

For most, the departure sequence begins when van drivers or family members arrive. It is usually staff who retrieve participants for departure and assist with coats. If more than one participant happens to be departing at a time, only one will be assisted with his or her coat in the vestibule/coat room, others will be assisted in the Great Room dining/activities area. Inevitably, the activities of departure become the focus of attention, which reinforces the air of transitions.

Accordion divider between the living area (left) and dining area (right) in the Great Room.

Between 4:00 and 5:00 p.m., the environmental atmosphere is one of apprehensive anticipation. By this point, Skylight participants who have been assimilated into the Great Room group often remain agitated following the room transfer. No doubt the room transfer has signaled the nearing of day's end, and departures underscore this. Individual participants begin repetitive verbalization of their concerns: "Who's picking me up? How am I getting home?" This atmosphere of anxiety is heightened as staff accommodate the participants' interest in the departure activity by turning their chairs to face the door. By 4:30 p.m., nearly all remaining participants have arranged themselves toward the door.

Primary program spaces

Days at Luther Manor begin with early arrivals who are supervised by one or two staff members. Participants drink coffee, converse in small groups, and watch television news in the living room. Most staff arrive between 8:00 and 8:30 a.m. and proceed to the daily staff meeting, held at a table in the dining/activities area. During this hour-long meeting, staff discuss each participant in attendance that day, and share recent experiences and observations about that participant. Participants are free to sit in on this daily staff meeting; at least one participant regularly does.

Following the staff meeting, Skylight Room participants are gathered and led to their separate program space, a procession that wholly secures the attention of the Great Room participants. Programmatically, the two rooms share a similar schedule, although staff note that activity sessions in the skylight room are generally of lower intensity and duration. According to staff, the primary differences between the two rooms are the sound level and subdued atmosphere. One of the most noticeable qualities of the Great Room is the change in light level from the bright dining/activities area to the dim living room. Though it has a generous row of windows along the west wall and numerous fixtures throughout the space, the living room area is plagued by low light.

Interior of Skylight Room.

ADC *Of all things, we didn't anticipate lighting to be a problem. I've looked into more floor lamps, but they're considered a fire hazard. I know it looks dark, but for our participants it hasn't seemed to be an issue, at least nothing we could point to and say that's because of the low light. We have good participation in activities. We don't have people falling asleep. We don't have any falls (knock on wood).*

Institute *To what do you attribute the lack of falls?*

ADC *I suppose people can see all right, they're not tripping on stuff, maybe the carpeting works really well. We have good staff. There's always staff around keeping their eyes on people. We don't have to restrain or tie them down so they're not trying to get out of chairs they don't want to be in.*

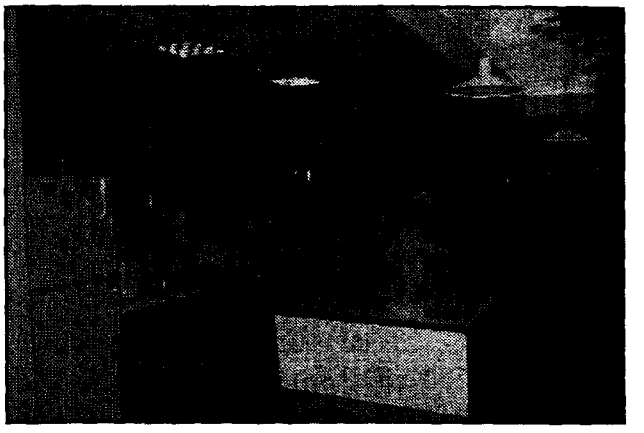
To promote maximum flexibility in programming, the Great Room features a variety of types and sizes of furnishings. Participants are free to move chairs wherever they like; arrangements change throughout the day.

Institute *You have two gentlemen who always elect to sit in one corner of the room. Do you think it important to have areas where people can observe activity but choose whether to participate?*

ADC *We're all different personalities and for some people the fact that they are just watching activities is more activity than they've had in a long time. They may be the sort of people who are never going to be up there tossing bean bags, but they want to watch it. I think it's good to provide lots of options. Also, some people really need to rest. If they don't rest they don't have they energy to sleep at night, or eat, or do the other things that they need to do. I underestimated the value of rest before I began here. When we first started we had continual activities and discussion groups--nobody was going to get one moment of rest. We felt like we had to constantly be bombarding participants with stimulating activities. We've learned over time that it's just as important not to overwhelm people with discussion groups and activities.*

Kitchen and kitchen work

Kitchens in the Great Room and Skylight Room are open in concept. The open plan is intended to invite resident use as well as provide space in which staff prepare snacks and serve the hot noon meal, which is delivered in bulk from the nursing home kitchen. The residential-style kitchen features a full size refrigerator, automatic dishwasher, range and microwave. Coffee is available to participants all day, made in a commercial coffee urn.



Galley kitchen in the Skylight Room with moveable island.

Food preparation activity happens three times each day, procedures that provide temporal landmarks for program participants. Some participants are regularly involved in the setting and cleaning up of meals and snack times. Kitchen-related program activities such as baking are often scheduled.

Institute *Can you talk a bit about the movable cabinet in the kitchen? How does that work better for Luther Manor than traditional connected work counters or built-ins?*

ADC *We very much like that you can walk all the way around them and you can make it smaller or larger by just flipping up the sides. We don't really move it that often. Our intention was that we would move it out into the room for baking activities, but it's too heavy. But that also means that it's sturdy enough to use it for serving meals, and we don't have to have our backs to the people all the time.*

Institute *Is it the island that you like or the fact that you can go all the way around it?*

ADC *Both. I'd seen several set-ups in the past and didn't like many. Especially those with the built-ins, with kitchens off to the side or through doors. You could see it, but it was not in the main program space. I like that our serving space is one you can walk around. We can see things, be more a part of the program, not separate.*

Institute *What are the advantages of having the kitchen integrated into the dining area?*

ADC *Kitchen smells and sounds are very familiar, and people really like them. A lot of the participants get their own water and coffee throughout the day. There is enough space that the wheelchair people can even go up and get coffee and water. I like all of that, that they have free access and can help us set the table and get prepared.*

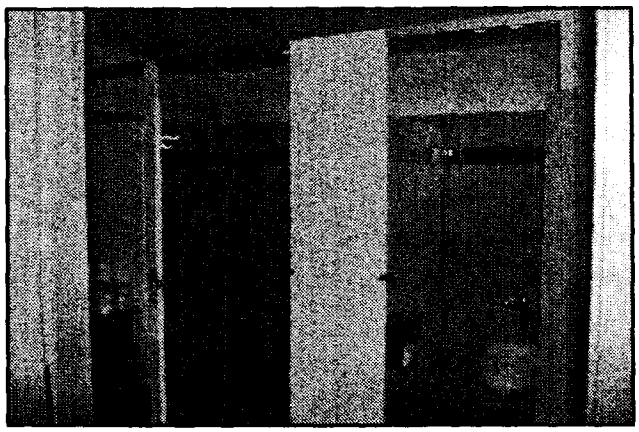
Dining

In both rooms, the dining areas also function as primary activity areas. Maximum flexibility was a key issue in designing these spaces. The hot noon meal is prepared in the nursing home kitchen and delivered in bulk in large steam trays. Plates for participants are prepared individually by staff.

Institute *What's the importance of having a range of table sizes?*

ADC *Some people like to sit with a small group, they're just not comfortable sitting with eight people at a table and would rather be with three or four. Then we have to consider the participants with special needs; we have so many people with special needs. The bigger we get the more that happens. So we need to have a space that we can use to accommodate bigger chairs, maybe three or four wheelchairs and staff intermixed either helping people eat or watching for choking. We have a few people who have odd or very disruptive eating behaviors that nevertheless still want to be in a group...here it's nice to have different sizes of tables so that they still have the illusion of being part of a group. It's good to have flexibility, to be considerate of the people who are really bothered by particular behaviors, and then there are some people who don't mind it at all.*

Mealtime conversation is another example of how you need to be flexible with your seating arrangements. One gentleman, when he was here, talked constantly. He didn't make any sense and would be pointing his finger and talking about the corporate blah, blah, blah.... He would have some of the more impaired women in tears because they didn't understand. We found success in putting him with people who couldn't understand much language but would nod their heads in agreement. That kind of flexibility is nice to be able to have.



Standard toilet stalls serving the Great Room.

Toileting

There are a total of six toilets to serve an average daily census of 48. Three toilets are accessed from the Great Room: one with three ganged stalls, a second for toileting with one-person assistance and the third for two-person assists. A fourth is located in the personal care/bathing room off the main corridor. The Skylight Room has one conventional sized toilet room located away from the room, along the room's entry hall.

Institute *You're finding in the Skylight Room that one bathroom is not enough for the number of participants in that space (12-13). The question is what ratio do you think would be appropriate: Is it two bathrooms for 12 people, so one to six?*

ADC *Two would really be nice. I would put in a second identical to the one we have, planning for the future possibility of needing equipment to transfer people from wheelchair to toilet. I'd plan for a room size big enough to put a commode in there if necessary, with plenty of space for a lift. Certainly I would ask the staff what they thought necessary. I'd probably spend time watching how the toileting procedure works for a couple of days.*

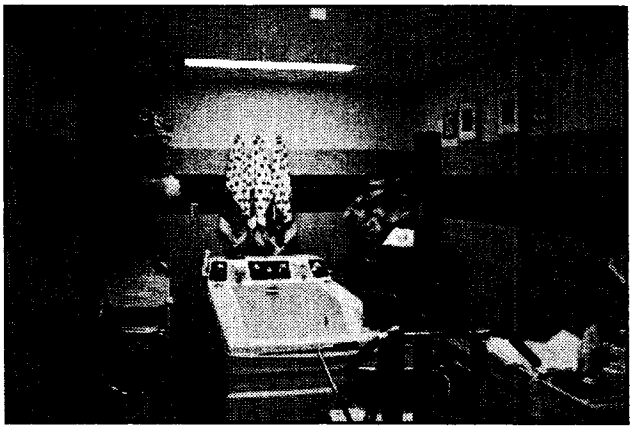
Institute *What do you see as the positives and negatives of ganged stalls?*

ADC *If you have a lot of participants who can go on their own or need only a little supervision, ganged stalls are fine. There's no waiting in line, more people can use the bathroom at the same time, and it requires fewer staff.*

On the other hand, ganged stalls are small. It's hard even if a little person with a walker tries to use one. They should be able to accommodate that, but they're really pretty small. Then add a staff person in there trying to help somebody pull their pants up or help them a little bit. You almost need to have the door open.

Bathing

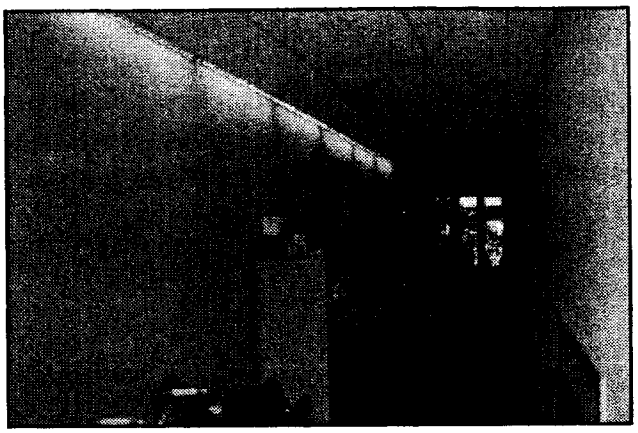
There is one bathing room outfitted with two tubs separated by a curtain, as well as a toilet and changing area. The room is located on an outside wall adjacent to the facility's main entrance and across the hall from the Great Room. Depending upon the number of baths being given, one to two staff members are assigned to bath assistance. Currently, 12 baths are given per day.



The bathing area is enhanced by plants, pictures and towels.

Institute *To be bathed, people have to leave the program space, out and across the hall. How well does that work?*

ADC *If we had it inside we'd have to really make sure that we were paying attention to all the noise factors... Bathing is very hard for some of our participants, and they're inclined to (verbalize) quite a lot. We don't want to upset the other people by having them hear all that. There's the noise of the tub draining, the staff trying to communicate over the sound of the running water or whirlpool or music and that could be disruptive. Plus the problems of the heat and humidity. One of the reasons it works now is that we have enough participant volume. Now we have a waiting list for baths. It's a much more popular service than we expected.*



Due to lack of use, the pacing corridor is now storage.

Wandering

The original design of the Skylight Room included a therapeutic pacing area. The pacing corridor is essentially a hall seven feet wide with entrances at the east and west ends. In practice, though, participants do not use the pacing area, and staff utilize the space for wheelchair and equipment storage.

Institute *It seems as though the corridor that you don't really want them to use, the long entry hall into the Skylight Room, has become the pacing area. They like to go down the hall, check the door, go back and forth. How do the staff and program respond to that behavior?*

ADC *We see this behavior in the Great Room, too, of people constantly going to the door if we're not engaging them. I think it's a challenge. We try to look at people's patterns and routines in the Skylight Room and work with them.*

Institute *One of the other things that seems to potentially lead to pacing in the skylight room's entry corridor is the location of the bathroom and the bathroom parade after lunch. Pacing seems to increase in the afternoon.*

ADC *Right. They have to use that hallway to get to the bathroom. If I had to do it again, I think the bathroom should have been inside the Skylight Room.*

Velcro straps may deter elopement.

Elopement

To date, elopement has not been a problem at Luther Manor. For the most part, Beth Meyer-Arnold attributes this to training, an alert staff and good design.

Institute *The design and location of the doors (at the ends of short hallways) appear to have mitigated elopement. However, the sight of the door seems to trigger some people's interest in trying to leave. How do you think that could be better addressed?*

ADC *I think doors and coats both trigger elopement behavior, but definitely for most of the people it's the door. You can hear participants thinking out loud: "I see people going in the door, there's people out there, there's the door, they keep opening it, that's the way to go." For others, the trigger will be the van drivers coming for somebody else. If we know we have a participant who's especially sensitive, we will put a sign up for a couple of weeks asking van drivers not to come in, please stop at the front desk. Reception can call in and we'll bring people out. I think it would definitely help if you could eliminate the sight of the door, but on the other hand, you know, they want to see the door, it's reassuring.*

In the Skylight Room, they can't see the door, and still participants have slipped out without our immediate notice. I think that the main door somehow has to be disguised. Being obscured in the darkened vestibule seems to help. The key is keeping people involved. Then they can forget about the door.

Institute *What about the main corridor on the other side of the door? Do you feel it gives you another layer of insulation before they get out or is it negative in that they're in a corridor and they can get into other areas?*

ADC *I do think the corridor acts as a barrier to interruption of the program and I think that's important. The activity of coming and going is very disruptive. The better we become at providing the right activities for people the fewer the elopements we have. It helps to know your participants, and to recognize that the weather influences behavior. We have to pay attention to the fact that there's a lot going on today, and it's beautiful out. Some participants have more sensitive times of the day that we have to watch for. For some participants, dealing with this kind of behavior becomes part of their care plans. That's one of the real benefits of having nurses here, to create care plans. It's about understanding the behavior, knowing that we're not always going to be able to prevent it, figuring out how we can use the space and how can we use the program to control things. It all works together.*

Advice For Other Providers

Institute *From your experience of the process or of the final product, what are one or two things that you believe are absolutely essential to the provision of good day care?*

ADC *I think it's important that 1) you have enough space, and 2) you have some dissimilar areas for variety's sake. I don't know if that's a good way to describe it, but I think having a space that people can walk to, where they can have a change of scenery is really essential. What you don't want is people sitting in one spot and spending the whole day there. If the person needs distraction, redirection, or has extremely short-term memory loss, then it's really nice to have two areas to walk in. It's a change of scenery, someplace you can say, "Come walk with me." Two spaces give you another tool for intervening, too. It's important to have the bathrooms accessible. You don't want to locate the bathrooms in the hallway where you have to leave the room every time you take somebody to the bathroom.*

And it's key to be aware of the security issues that you're going to have to face. It's really ideal if you only have one door in and out, but if you can't control that then you'll have to pay extra attention to entrance and exit issues.

Institute *In terms of one or two things, if you had to do it all over again, what would you like do differently?*

ADC *Well I'd love to have that extra space in the Skylight Room that is set aside now for the pacing area. I'd eliminate that wall, which would give us more room, a bigger space for the Skylight Room. Then I'd rearrange the dining area, make it more versatile and have more area available for the living room. Of course, I'd put in another bathroom. I'm really glad that we have all the storage that we have, but it would be great if we had more.*

Catholic Charities Adult Day Services and Resource Center
Milwaukee, WI

Theme
Something old, something new.

What this case study shows:
· Past experience is important, but it can impede realization of future goals and objectives.
· The outcome of conflicting objectives. In this case, the key decision to implement an open concept space prevailed over the desire for a home-like atmosphere.

Place Profile

Director
Cathy Young

Site/context
Located on Milwaukee's near west side, straddling an upper middle class with historic register houses and a lower income district made up of small homes and rental flats.

Facility type
Purpose built, stand alone facility

Building size
6,000 gross square feet

Estimated cost/square foot
Approximately $105

Architect/designer
Cerreta Group, Waukesha, WI

Program

Mission and goals

Inspired by religious values and Catholic social precepts, the mission of Catholic Charities is to build a caring community by providing social services to those in need and by advocating for justice and equality for all. The goal of the program is to help frail elderly with dementia help themselves to live as fully as they can for as long as they can in their own homes. To ensure each participant experiences a full and rewarding day, Catholic Charities has sought to create a safe, comfortable and secure environment. For caregivers, Catholic Charities offers support, assistance, encouragement and rest.

General description

Catholic Charities has been providing adult day center services since 1981. The current day care program outgrew its initial facility in the basement of an Episcopal church. Following an independent consultant's recommendations regarding strategic issues, planning and development for a new facility was initiated in 1993. The new site opened in November of 1997.

Catholic Charities provides services to its participants and their families from 7:00 a.m. to 5:00 p.m. Monday through Friday. Although the daily fee at Catholic Charities is $34 (or $18 for four hours or less), the center adheres to a policy of contribution. All participants are mailed a monthly contribution envelope to which they may donate what they can for the cost of service. No person is denied service or penalized for not contributing.

Services offered on a daily basis at Catholic Charities include:

- Personal care (personal hygiene, bathing, nail and hair care)
- A hot noon meal, plus morning snack
- Health maintenance (blood pressure checks, supervision of medication)
- Individual needs (physical and occupational therapy as prescribed)
- Activities (on-site and occasional field trips)

The program at Catholic Charities takes place in the large, multipurpose room. In general, one activity is conducted at a time. A morning snack is often followed by range-of-motion exercise, discussion of current events, an activity, lunch, and an afternoon activity. Occasionally, a large-group activity such as a sing-along, may occur simultaneously with a small group activity such as crafts, a game, discussion, or rosary. In this case, one activity is conducted in the multi-purpose room, and the other in the adjacent sunroom/chapel. Mass is held twice monthly.

Staffing

Reporting to the director/administrator, Catholic Charities has a total staff of 13, of which six are FTE. Among these are a social worker, RN, activity coordinator, six nursing assistants and four activity assistants. The staff to participant ratio ranges from 1:8 to 1:4 if more than 25 percent of participants are severely impaired. The center also has two consultants, one in social work, another in recreational therapy. Eleven of the 13 employees are age 45 or older. The length of time that most employees have been with Catholic Charities is remarkable, with 80 percent having been with the program ranging from 11 to 16 years. The director comments:

Institute *To what do you attribute your staff retention?*

ADC *It's a lot of things. It's the atmosphere, the working conditions and their dedication to what we're all about. I really do think a lot of it is that we do sit down with staff and have meetings. We like staff to feel it's their program. It's so rare in long term care to have staff feel that the facility is their facility: It's a job. We know that all these people are not paid very much, and probably paid much less than in hospitals and nursing homes. But our staff are not here for the money. We have a family atmosphere and staff work well together as a team. We talk to the staff. We listen to*

our staff and validate them and let them know how valuable they are.I tell everyone that our program is the staff. You can have any building, but if you don't have good staff and good programming it doesn't make a difference. We were successful in the basement of a church. We had the census and solid staffing. It's ongoing to keep that with staff. It is a lot of work to keep staff happy, especially when they can go out and get $2 an hour more--of course we struggle with that. It's just an ongoing process.

Institute *You've said that in some ways the transition to this building was more difficult for staff than participants. In what ways?*

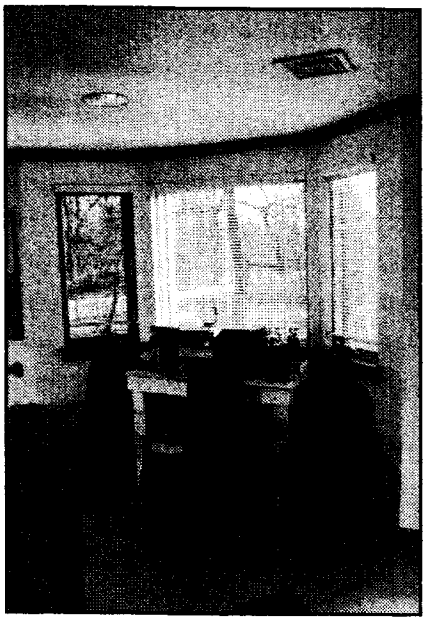
ADC *Some of it was adapting to the larger size and issues of timing. From a practical standpoint, before, when the bathroom was literally right next to the activity area, it was really easy to get someone to the bathroom. Now that the toilets are located in a more appropriate place, it takes longer to get people there. It's getting the timing figured out.*

It's also taken some time to figure out the best ways to best utilize the space we have for activities--adapting to the different spaces, different demands and growth is challenging. To adapt to having ten new people in the program within a month or two, as we did pick up our census, that takes time. One of the things that I think we do well is to know the participants when they come in, to know their needs, their past history, family and everything. When you have so many people starting the program all at once, to be able to give them individualized attention takes a little time. We had to adapt to that. It was a faster pace. After a year I think we're still looking for ways to improve and change.

Participant Profile

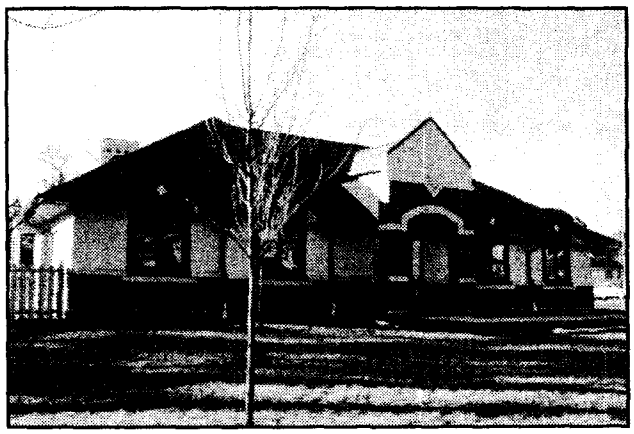
Catholic Charities has 80 enrollees (up from about 30 in the former site), a maximum capacity of 50, and a daily average of 45 persons. Most participants attend for seven to eight hours per day.

Participants are 50 years and older, with an average age of 82. Males make up 40 percent of participants, 60 percent are female. Sixty percent of participants are cognitively impaired, 10 percent of participants use wheelchairs and 40 percent of participants are incontinent.



A window bay with a view to the outside.

Physical Setting



Catholic Charities front facade.

The Catholic Charities facility is a single story building of brick and stucco with a low slung shingled hip roof interrupted by shallow arches that accentuate the windows.

The arched-top porte cochere (covered passageway for vehicles) has brick piers topped by columns. Overall, the design of the day care center facility is suggestive of the vernacular bungalow (one story cottage-type houses) that populate the surrounding neighborhood.

Program spaces are classified in terms of three primary areas: activity spaces; administrative spaces; and support spaces. While administrative and support spaces are located at the "front of the house," the activities spaces are located in the back half of the facility, furthest away from the parking lot and main entrance, a configuration calculated to reduce disruptions. The large multipurpose room (30' x 40') is used for dining on one end and activities on the other. The room adjacent to the multipurpose room is the center's second activity space, generally referred to as the sunroom/chapel. The administrative offices are located off the main entrance. Support spaces include therapy, respite, men's and women's toilet rooms, a personal care room, beauty shop and laundry.

Conceptually, the design of the Catholic Charities facility is based on what program leaders had learned in the past. "From experience, we knew what we wanted," Young says. An open concept and a warm, home-like atmosphere were the two primary objectives for the new facility. The decision to limit the program to 50 participants was also relevant to the design.

Institute *Were there any specific things that you'd experienced in your former space that played into the design of your new facility?*

ADC *Several things. The day care at St. Timothy's had one room facing a funeral home and parking lot where participants would see all of the vans. We liked the windows and sunshine, which is why we did this design (with many windows). It helps when people are aware of the environment and lets people know what it's like outside. The other room was very dark because it didn't have large windows, just a church basement type of a window. It was dark and gloomy and it affected peoples' moods. In our new building, they can look out. They can see our patio and our wander path.*

Institute *Some day care providers feel that windows are too stimulating and disruptive.*

ADC *Yes, I agree that it can be very disruptive. If it's on a busy street it can be. This new facility was designed intentionally to provide a view onto a peaceful setting with birds--there are bird feeders out there--as well as nature.*

The large, rectangular multi-purpose room is done in a color scheme of burgundy and teal blue detailed by wood accents. The room features a vaulted ceiling, indirect lighting, windows with views to a wooded outdoor area and a gas fireplace at one end, all elements that contribute to the impression of a lodge. The activity area of the multi-purpose room is focused toward the fireplace. Located at the other end of the room is the center's kitchen, a separate room that is available for participant use only during specific activities. The kitchen has a pass-through window to the dining room, which, when not in use for serving meals, is closed off by a metal tambour door.

Half-walls define the perimeter of the multi-purpose room. A course around the room's periphery is suggested by dark green tiles laid every few feet in an effort to demarcate a wandering path. Although initial plans called for carpeting on the activity half of the multi-purpose room, floors throughout the facility are white vinyl tile. Although the director cited the need to keep the floor clean and odor-free as the primary rationale for going with tile exclusively, in combination with the vaulted ceiling and predominance of other hard surfaces sound reverberates and echoes in the large

Institute *How is the tile flooring working out?*

ADC *We're happy with this choice for cleaning. We looked at carpeting. I went to the facilities that have Flo-tex. I talked to the maintenance people, and although I heard it is relatively easy to maintain, some people said they had to rip up a lot of it anyway, and I just didn't want to get into that. I did like the way it looked. It was picked out and then we decided just to go with the tile. I think we're glad we made that choice. The offices are carpeted because the carpet was donated. Considering our participants, with their wheelchairs and walkers and everything, tile has just worked out.*

The multi-purpose room is furnished with sofas, tables and highback chairs with wood arms, vinyl seats and some with fabric backs. The dining area features rectangular eight-person folding tables.

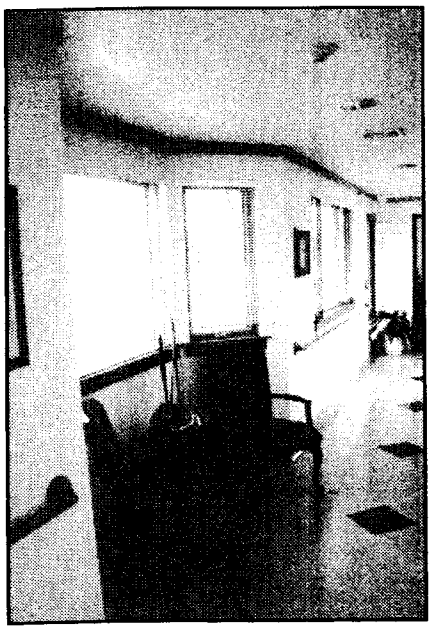
The sunroom/chapel, about one-third the size of the multi-purpose room, serves as a secondary program space. This room has a dropped acoustical tile ceiling, rectangular fluorescent fixtures and white tile flooring. Located along the inside wall is a storage closet containing information resources on aging. A folding accordion door is used to divide the room in half. Although the portable altar is stored in this room, it is moved into the larger activity space in order to accommodate the large number of Mass participants. Windows on two sides of the room look out onto the outdoor naturescape and admit natural light.

Floor Plan: Catholic Charities

Coming and going

Arrival times at Catholic Charities begin as early as 7:00 a.m. and continue as late as 11:00, but most participants arrive between 9:00 and 9:45. Most are conveyed via county transport van, each of which carries between six and eight people per trip. From 9:00 to 9:45, as many as four vans arrive simultaneously. Departures begin as early as 1:00 p.m., although most occur between 3:15 and 4:30.

People enter the facility through the main entrance under the porte cochere, which faces the parking lot. While the porte cochere is designed to protect people from inclement weather as they enter the facility, in reality not all transport vans utilize the covered entry.



Sitting nook with a view.

Institute *The covered entrance in front of the front door appears too narrow for vans. We observed this morning that a few vans don't even go under it.*

ADC *When the architects were designing it, they met with some of the transportation companies and got measurements for their vans. Unfortunately, just after that a different transit company took over the system. They came from another state with these huge vans, and that's why the porte cochere is inadequate.*

Once inside, participants are helped out of their coats in the narrow entry hall. Staff take participants' coats to a closet located near the administrative offices, where each coat is hung on an assigned hanger labeled with each participant's name. The obscured location of this closet is designed to eliminate elopement cueing that can result when day care participants see their coats.

Institute *Other adult day center centers de-emphasize their front doors from the activity or dining spaces. Here, your front door is visible from most parts of the main room. Was this intentional?*

ADC *It's less visible here than in our former space, and because one of our objectives was to be open in concept, the door is just obvious. In our experience, doors in general are not necessarily a problem, and in any case, this main door is not the door the wanderers use. They find the back doors that are hidden. At St. Timothy's the entrance opened directly into our activity room. Here at least we have the reception area, the desk and two doors, so that if we do have someone who wanders and they get through the first door (which is alarmed), they're unlikely to get through that second door. In terms of security, this is much better.*

More than seeing the door, our bigger concern was for people to not see all the vans coming and going. In our space now, participants are seated in a way that they can't see the van traffic, where they can't be distracted or upset by all that commotion.

The activities area.

Primary program spaces

For the most part, Catholic Charities participants are seated in the multi-purpose room and engaged in one activity. A typical day's schedule consists of a morning snack, exercise session, discussion, an activity, lunch, and an afternoon activity. Occasionally, a large group activity occurs concurrent with a small group activity, such as crafts, a board or card game, discussion or rosary. At these times, the sunroom/chapel is used for the smaller group.

Sunroom/chapel.

The sunroom/chapel is also used as an alternative program space when the participant group is divided by cognitive or functional ability level. For example, 10 participants who need mealtime assistance take their lunch in this room. In addition, the quiet of the sunroom/chapel makes it ideal for refocusing disruptive participants and for napping.

Institute *What activities take place in the sunroom/chapel?*

ADC *They do crafts. They have small group discussions, exercises for a very low-level group. They play with balloons and balls and have real simple discussions. There is a small percentage at a very, very low level and they need one-on-one attention in order to draw out any response. Sometimes we do a health and beauty activity, or they will do their nails and hair and just talk. There is a rosary time. We have a group that likes the traditional rosary or church services.*

Institute *What about when participants want to be alone or simply need some rest? Do people use the sunroom/chapel that way? Can people just be by themselves?*

ADC *There are a couple people who like to isolate themselves, though we have surprisingly few. We have opportunities for them to sit alone. We have a couple of*

gentlemen who like to sit in the sunroom and watch TV or play cards. It doesn't come up often, but some of our very alert people sometimes just want to sit alone. They know where they can go when they want to be.

Institute *Where would they do that?*

ADC *A lot of times they choose to sit in the window bays (in the multi-purpose room). There, you can sit alone, but not be too alone. Some might sit at a table and play cards or do a word game. There is a gentleman who likes to go to the chapel and sit there, but he is one who comes in and out of an activity. He stays a little while and then he needs to get away--he knows that about himself. When he needs to lie down and rest he goes to the respite area. We have very few participants who really want to be completely alone, especially once they get into the program.*

The truth is, with most of our participants, these are people already who spend too much time alone. They're alone at home. We have people who feel isolated in other settings, who feel isolated when they're with their own families. Families do not like them to be alone while they're here. Most of the time we find that they do engage in some activity, even if on a limited basis. If they're here they want them to be in the program, to be active. The physicians want them to be active, to be involved. Everybody is different. That's something that we learn from our assessments too, to know if the person is a loner and to understand past activities or interests is important. The point is, we don't push anyone to get involved in an activity. Sometimes there are reasons why, and that's our chance to really assess what's going on. If they want to sit to the side that's fine.

Kitchen and kitchen work

The kitchen at Catholic Charities is not a participant space. The director believes this approach is safer and more appropriate for participants with dementia. The configuration was also intended to isolate the noise associated with meal preparation, thereby minimizing distraction while program activities were being conducted. However, when staff are preparing meals, the rolling metal window partition is open to the general program space.

The kitchen is primarily for staff use.

Institute *While other day care centers might have the kitchen more open to the dining area, we've noted your desire to have that room, for the most part, closed.*

ADC *For participants it's closed when there's a lot of activity in the multi-purpose room. This afternoon there's a cooking group scheduled--then it will be open.*

Institute *So the participants will be in the kitchen?*

ADC *They can go in and help cut things up. A lot of times participants will be helping and working at tables in the dining room area--it's easier because so many people are in wheelchairs. When no one's working in there, we do close the kitchen off for safety reasons. We do have two people who could go in there and wouldn't know if they put their hand on a hot plate, or who would go in and pick up a knife by the wrong end. Those are things we are really concerned about. Some people may be on special diets and they don't understand that they shouldn't have certain foods. Those are reasons for keeping the door closed.*

Institute *Do participants ever want to go in the kitchen, be a part of that activity?*

ADC *No. They want to be served. Seriously, they like to be served. We do have some women in the morning that help make the coffeecake. This afternoon they are baking bread. We have bread maker machines. They stand around and watch that activity and are a part of it. A lot of our discussions are about cooking and baking. They talk about their favorite recipes, how they used to bake bread. It's more than just the activity of baking bread. At other times, it is closed.*

Pass-through from the dining area into the kitchen.

Dining

In both rooms, the dining areas also function as primary activity areas. Maximum flexibility was a key issue in designing these spaces. As noted, meal preparation and plating are carried out by staff in the kitchen. Participants are served restaurant-style at their tables.

ADC *We set the tables differently at different times. Sometimes we have them face the other way, and so there is a lot of flexibility. We've used banquet style and all different ways, especially for the different holidays we change things around. Originally we talked about round tables and the pros and cons, because we have had round tables before. When you have round tables it leads to more discussion and interaction. But some of our people wanted to isolate themselves, and they feel they can do that at a longer table. So we switched our thinking to longer tables.*

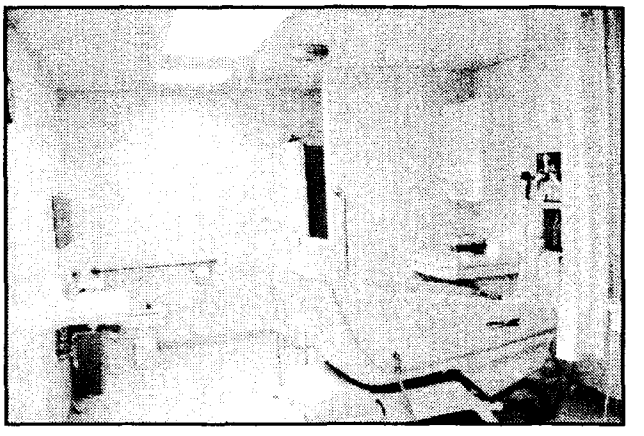
Institute *Do you see any disadvantages to long tables?*

ADC *It's maybe harder to converse, but then we've put the tables together because (the participants) liked it that way. The tables used to be apart and then we found that*

the participants liked them together. So we said, "If you like the tables together, we'll put them together." They like the family atmosphere--it's like at Thanksgiving where everyone is together. We'd fit more people if they were separate, and it's easier for staff the other way, but this works out fine and we do it the way the participants wish.

Toileting

Catholic Charities facility has six toilets to serve an average daily census of 45. The rest rooms are not visually accessible from the multi-purpose room and at times, participants were observed requesting staff to assist them in locating the rest rooms. The rest rooms were intentionally placed away from multi-purpose room, in part as a reaction to the toilets at the program's former facility, where they opened directly onto the dining room.



Bathing room.

ADC *Now there is more privacy in that it's set away from the activities. I think it is important to give people privacy. They are all wheelchair ADA accessible, which we didn't have before. The restrooms were designed specifically for a setting this size with a population of this many people. We talked to the CNAs--the people who really do the toileting. It's easy for advanced architects and other specialists to create designs, but they didn't always know a lot about the really practical, basic things that need to be considered. For example, it turned out that we needed to have this wall reinforced because we had to put a bar in here--that wasn't in the initial plan. Staff knew that it was important to have a toilet next to the bathing area, and originally there was no toilet next to the bathtub, because other facilities didn't have that. That's why you want to include staff in the process--those are the kinds of things staff contribute to making a better facility.*

Institute *Do some people need two-person assistance?*

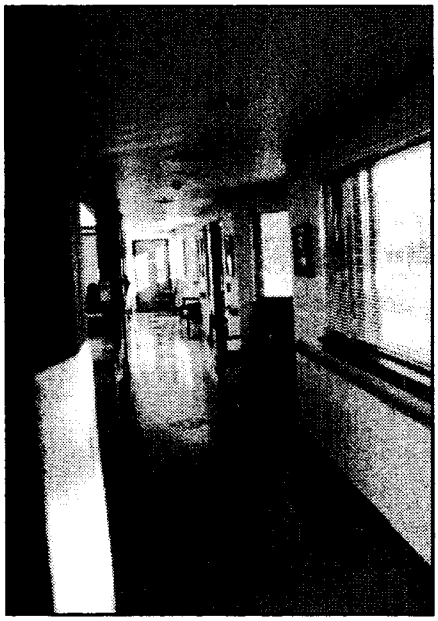
ADC *Yes, two and three.*

Institute *Two and three?*

ADC *Well, we didn't really want to get into chair lifts for a lot of different reasons. So the staff started thinking about how we could do it, and it works out beautifully, because the bathing room it is just a huge space and it's easy to do it. If it's a three-person transfer we have that room to use.*

Institute *Do you find that more participants ask for assistance?*

ADC *Not really. We have a percentage that really just know and can go on their own. We don't find people asking for assistance just because the toilets are down the hall. That's primarily because we know when they come in who needs assistance and who doesn't. Through an admission assessment and other assessments families will tell us who needs incontinence care. You just have to be aware, and recognize that needs change over time.*



Wandering path.

Wandering

On the periphery of the multi-purpose room, Catholic Charities has a wandering path, set apart from the room proper by half walls and columns, and marked by a course of widely-spaced dark green floor tiles. Well-intentioned, the wandering path has two weaknesses. The first shortcoming results from the use of dark tiles; observation indicated that some wanderers avoided the dark tiles, perhaps perceiving them as "potholes." Problematically related is the broken pattern of dark tiles set in the ground of white; researchers observed the inconsistency pattern appeared to confuse some people. The second weakness of the wandering path concerns its course and the customary location of program activities. The path defines a route that circles the perimeter of the multi-purpose room, the west end of which leads it in front of the fireplace, the place where the majority of activities customarily take place. So, rather than walking through the group activity, wanderers will usually walk along two or three of the path's sides and stop, or continue through the sunroom/chapel.

Institute *The majority of your participants are engaged in a scheduled activity that goes on in front of the fireplace most of the time. You also have a few people who wander.*

ADC *The people (right now we have two) who wander and use that path have dementia and Alzheimer's. They go back and forth. They go to the door of the sunroom, look at all the windows and walk back. They generally don't go through the door. They just look into the sunroom, and then they go back again. When there's nothing going on (in front of the fireplace), they know they can go (through). You know, they could also go into the chapel rather than going in front of the fireplace to make the circuit if they wanted to.*

Institute *What happens when there's an activity in the chapel? You mentioned that sometimes you have an activity in there and you close the door to maintain quiet.*

ADC *It's fine by our staff to have someone with dementia coming in and out of activities. They close the door to keep the noise down, but it's certainly OK if they go in to look and see. Maybe one will want to sit down and participate in that activity. That's why it's kind of open. Even though they're wandering, they may stop and participate, that's OK. A lot of times when we have two group activities going on, those wanderers will become interested in one of those activities. You'll see that when there is no activity going on that's when most of the wandering occurs.*

Institute *Is it disruptive if someone wanders through an area when there is an activity?*

ADC *The people we have now seem to walk past. They don't stop or they don't talk. They just wander; they look to see what people are doing. If there's a low-level activity going on in the sunroom/chapel, of course staff will try to engage them in the activity. If a staff person knows a wandering participant might be encouraged to come in and sit down, they will ask. That's typically what happens.*

Institute *You haven't found that to be too disruptive?*

ADC *Not with the participants we have right now. This is one of the reasons for having two groups. Certainly it's disruptive if someone is getting up and down, knocking people in the arms, but the staff know the participants very well. They know who is likely to wander and who is not, and where they should sit so they can get up and down with the least disturbance. They're sat toward the back of the room.*

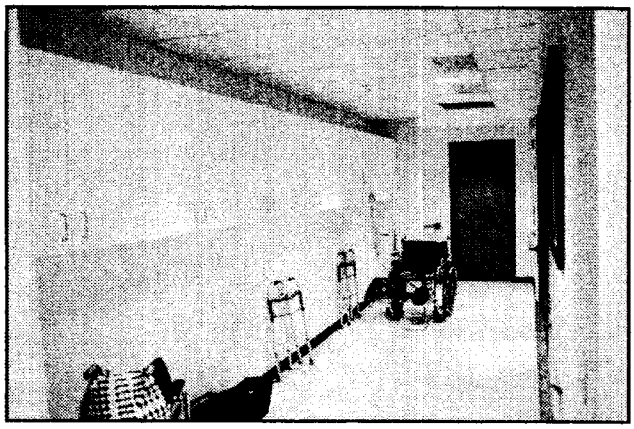
Institute *We know of some day cares with multiple activities where they literally close the rooms off for the purposes of avoiding disturbances from wanderers. What's your opinion about that approach?*

ADC *I would hope that there would be some alternative avenue for people who wander, some activity that they could engage in if they wanted. I know that we have two participants who were asked to leave other Alzheimer's programs because of their wandering. One woman wanders all the time, but we don't view it as a problem. Perhaps it's just our attitude and our experience. If you close the door to someone with Alzheimer's, they are going to find a way to open it.*

We are fortunate in that we really have only two people who are at risk of being potentially disruptive. If we had maybe five or ten, now that would be a different story. Then we would reevaluate our program. I can see how a facility with a high level group couldn't tolerate it. You have to consider a lot of reasons for the negative behavior. Sometimes people are disruptive because they don't like the facility. That hasn't been a problem for us here. I would hope that all adult day cares would provide other avenues for those people, that they just wouldn't wander all day long. I think they would want to engage them one-on-one even for 20 minutes if they were able to do that.

Institute *When you look at the wandering path and recall your original intentions for it, do you think it's achieving what you wanted?*

ADC *The way we use the building is different from how we originally envisioned. What works better for programming and seating is what you see, and participants really like the fireplace when it's on. Sometimes they do have activities that are going on in front of the wander path. But people can walk behind it if they want to, although we haven't really found that people continue to walk the path. They really do want to go to the sunroom. Cognitively they're not able to follow the path.*



Corridor to back door.

Elopement

There have been no elopements to date from Catholic Charities. However, it is not unusual to hear exit alarms sound several times a day. The elopement location of choice is a back door, down a corridor near the bathing room. It seemed likely that wanders recognized this as the only door that was routinely out of view from staff and other participants because elopement attempts would be made at this door only, not the main entrance or the side door next to the kitchen. The organizational response to attempted elopement is for staff to "drop and go," save for the staff person who is leading the scheduled activity. Participants typically showed no reaction to these episodes.

ADC *We have been very fortunate we haven't had anyone elope from the building. Other facilities have and most day cares have. Our good record is probably the reason why we have two particular people in our program. Both had eloped from other facilities and they didn't even know they were gone until it was time to go home, and then they realized two people were missing. That's hard. We are just fortunate it hasn't happened. I don't think it is a bad facility if elopement happens; in some ways I think it's inevitable.*

Institute *Do you have any thoughts on why wanderers tend to go for the doors that are more concealed?*

ADC *Well yes, it is interesting to theorize about that. I think participants know that we're stationed at some doors and they avoid those. Others don't exactly have a goal or destination in mind for where they're going; they seek out quiet areas, like this remote corridor and they simply try to open the door. Then we have people who try to open every door all the time, who aren't cognitively able to differentiate one door from the next. We have one woman like that. She starts out with the door in the back, and then continues on to each door where she sees an exit sign.*

Advice For Other Providers

Institute *What advice can you give to other day care providers when considering designing a new facility?*

ADC *Ask families, ask your caregivers and staff for their ideas. Get their input because administration doesn't always know what's best. Look at other sites to see what works for them and what doesn't. We did that. Ask people who built other sites. Sometimes people aren't really open to talk about those things, but if they are, ask them what worked and what didn't work, what's underutilized and what's utilized a lot. Decide the type of participant population you want to serve. Be very, very flexible and willing to make changes. Knowing how much money there was and how much things were going to cost was important. We had to compromise on some things, to eliminate some because we wanted to include others. Guard the things you believe are most important.*

Institute *What are some things that you really didn't want to compromise on?*

ADC *The personal care room, for its privacy, and the extra toilet in the personal care room. The bathrooms. And the fireplace. I thought it gave the place warmth and a unique look. It's the little things that make the difference.*

Shepherd House
Milwaukee, WI

Theme
Upstairs, downstairs.

What this case study shows:

- The challenges associated with having an adult day center located in a basement.
- How to maximize the programmatic benefits of a constrained physical location.
- How decisions that maximize organizational and staff efficiencies impact participants.

Place Profile

Director
Sr. Edna Lonergan

Site/context
Located in a middle income residential neighborhood on Milwaukee's south side

Facility type
Adaptive reuse of a convent basement

Building size
Approximately 6,300 square feet

Renovations
Four renovations over 15 years:
1) dementia-specific space, called Leandra Hall
2) a pacing area
3) a space for the very old and frail suffering from chronic physical disease with moderate dementia, named St. Francis Hall
4) a dedicated therapy department space

Architect/designer
C.G. Schmidt, Milwaukee, WI
(first and second renovations)
Cerreta Group, Waukesha, WI
(third and fourth renovations)

Program

Mission and goals

ADC *The mission of the Sisters of St. Francis of Assisi is to serve the underserved. At the time (of the day care program's inception), the underserved (as determined by the community needs assessment) were very frail older adults who were just being placed in institutions, regardless of whether they needed it or not.*

General description

The adult day care program of Catholic-affiliated St. Ann's Shepherd House began as a nursing home and rehabilitation program for aging nuns that was opened to the public in 1983 following a community needs assessment. The program serves physically frail adults over 60 years of age, as well as those suffering from dementia.

Adult day care at Shepherd House is provided in two spaces, Leandra Hall, a room dedicated to the needs of individuals in moderate to severe stage dementia, and St. Francis Hall, where care is provided to very frail adults over age 85 with moderate dementia. The hours of operation are Monday through Friday, 6 a.m. to 6 p.m. Though the daily schedules of Leandra Hall and St. Francis Hall are distinct to reflect the different needs of each population, in general, the program offers:

- A hot noontime meal, as well as a morning and afternoon snack.
- Programmed activities (exercise, storytelling, crafts, music).
- Access to daily mass, which is held in a chapel on the building's first floor.
- A monthly liturgical service, held in Leandra Hall.
- Health care (i.e. nursing, dentistry, dermatology, optical, podiatric) on an as needed basis.
- Personal care (i.e. toileting, bathing, medication) on an as needed basis.
- Physical/occupational therapy on an as needed basis.

The daily charge is $43; many participants' fees are subsidized by private and public sources, which are arranged by the organization. Sr. Lonergan describes the intention of each program:

Institute *Let's talk about the programmed activities in each room.*

ADC *In St. Francis Hall the participants have more choices. There's usually two activities in the morning and one in the afternoon, but then a lot of one-on-one activities. Someone may sit down and play games, or there may be a baking activity going on in the kitchen and another activity going on in another area. Sometimes we've had three activities going on at the same time. We've had one back here in the family room and one in dining room, another in the kitchen, so people feel like they have a choice. We play it by ear, but we've found that people in St. Francis still benefit by having a choice of activities.*

Institute *It seems that in the Alzheimer Room the activities are more focused and structured. Is that intentional?*

ADC *Right, we've developed specialized activities for this population. The activities in Leandra Hall are very structured and very simple. They're usually coupled with immediate gratification, prizes, and awards.*

Staffing

Shepherd House has a staff of 28 of which 21 are full-time employees. In Leandra Hall, the moderate to severe dementia population necessitates a staff to participant ratio of one to four. In St. Francis Hall, the population of very frail, over 85, and moderate dementia has a ratio of one to four or six, depending upon ADL needs.

Participant Profile

Shepherd House has 90 enrolled participants, a maximum capacity of 50, and an average daily census of 48. Its participants are all over 60 years old, with an average age of 77. Caucasian participants make up 96 percent of the census, three percent are African American, and one percent is Hispanic. The male to female participant ratio is 1:3. All participants have some level of cognitive impairment. Thirty-one percent are in wheelchairs; incontinent participants make up 74 percent of the participant base. Shepherd House draws its participants from a wide surrounding area:

ADC *We cover about 14 different municipalities for Milwaukee County because there's not enough adult day center centers that are comprehensive. Just to have a social card playing day care is not where it's at. People can go to the senior clubs for that. What people really need is comprehensive care. People want one-stop-shopping. They want to know that their loved one is well cared for and that they don't have to take off to take them to the beauty parlor, to take them to the foot doctor, that everything they need is going to be covered, but that they can still live at home.*

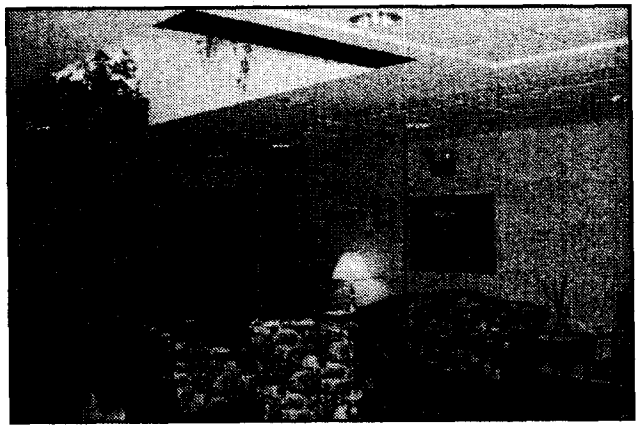
Physical Setting

Shepherd House's primary spaces are located in the basement of a convent, and consist of a reception lounge and two program rooms (St. Francis Hall and Leandra Hall) connected by a long central hallway. Access to the basement level is by elevator or stair. Toilets, administrative and nursing offices and bathing rooms are located along the central corridor. A pacing corridor is adjacent to Leandra Hall.

Although the day care occupies the basement of a convent, careful planning and thoughtful renovation has resulted in a warm, homey and pleasant atmosphere. Exiting the elevator, the reception/lounge is the first space encountered; it features hardwood parquet flooring, wood paneling and patterned wallpaper. Coats for St. Francis Room participants are stored in an adjacent closet. From the stairs, one lands in the central corridor with vinyl tile flooring, treated to eliminate glare.

To the left along the corridor is St. Francis Hall, which consists of one large space divided into two zones--activities and dining--as defined by furniture arrangements and flooring materials. An especially nice feature is the working fireplace. Natural light is admitted through windows on two sides of the room, and supplemented by fluorescent lighting in the activities area. The kitchen, which is open to participant use, is adjacent to the dining area.

View of St. Francis Hall.



View of Leandra Hall.

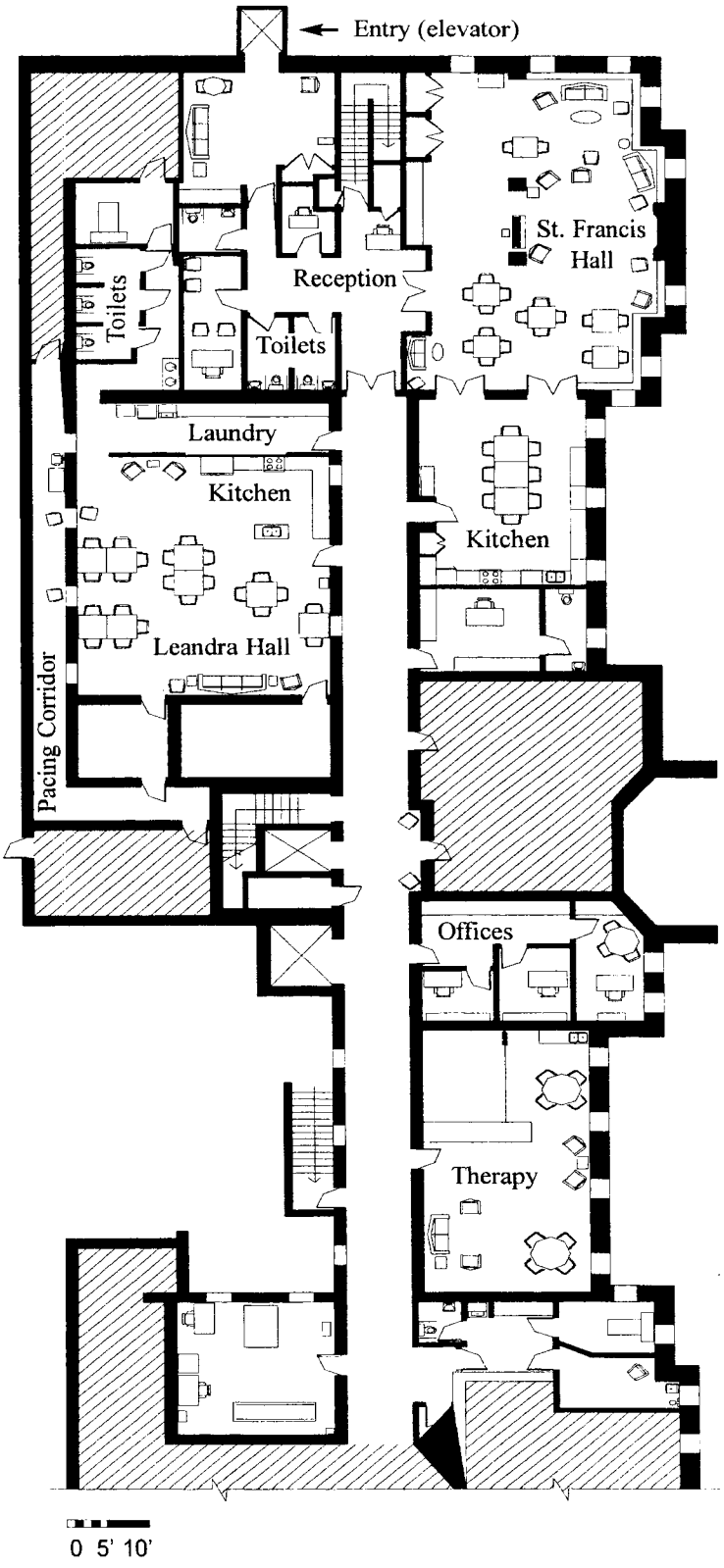
View of Leandra Hall.

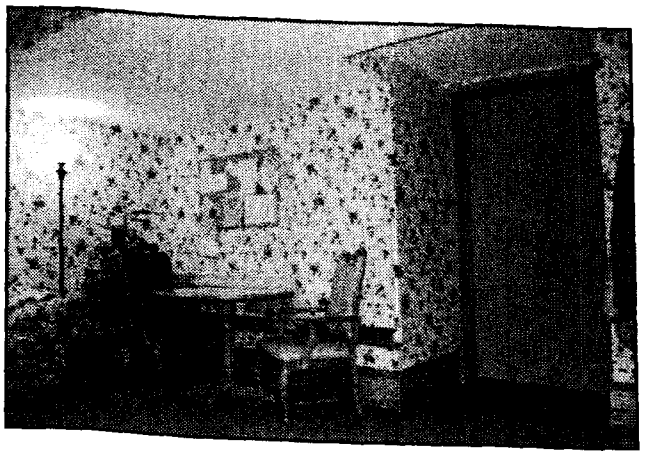
Flooring is vinyl tile in kitchen and dining areas and carpet in living room. Furnishings are a mix of types and styles, including high back chairs, loveseats, gliding rockers and arm chairs. Square dining tables in the kitchen area seat four, and are used informally by participants for conversation and playing cards. All furnishings are easily moveable, providing flexibility for programming. Toilets for St. Francis participants are located down the hall.

Further along the corridor and to the right is Leandra Hall, the Alzheimer-specific room. Windows line one side of the room; skylights and incandescent can lighting supplements the abundant natural light. The room is carpeted throughout. Along the outside wall of Leandra Hall is a pacing corridor, which is visible from the program room through interior windows. A galley-type laundry area, separated from the activities area and kitchen by a screen wall, houses machines for washing dishes and linen; at the end of the galley is a closed, alarmed door that leads to the main corridor. Toilets for Leandra Hall participants are located away from the activities space, opposite the laundry area. Adjacent to the dining and activities area is a locked mechanical room that houses environmental controls for the entire building. Coats for Leandra Hall participants are stored down the hall in a closet/storage room.

At the end of the corridor lies the therapy room, which is currently under renovation in order to provide program space for participants in late stage dementia. Upon completion of the renovation, this room will have areas for resting, changing, a living area, a dining area and kitchen.

Floor Plan: Shepherd House





A warm reception.

Coming and going

Participants are transported to Shepherd House by various modes: Shepherd House van, county transit system, Transit Express and caregivers. Arrivals are staggered, starting from 7:00 a.m., with most participants arriving before 9:30. Participants descend to the program space by elevator or stairway, depending upon their physical abilities or how they're feeling that particular day.

ADC *Many of our participants with Alzheimer's disease actually don't have the physical disability so a lot of them come in by way of the stairs. I'd say that the great percentage of them do. We like to encourage them to do as much as they can. For our people with Alzheimer's disease, their problem is not physical disabilities, their problem is dementia, and until they are in more profound stages they can usually manage the stairs and it's good exercise. There's the option of coming down in the elevator, but a lot of them do come down the stairs.*

Coats and outerwear are removed in the reception lounge with the assistance of staff and stored in closets located outside the two program rooms. Then participants are ushered into program rooms.

Most departures occur between 2:30 and 4:30 p.m., and 5:00 at the latest. Most often, the drivers come down to the reception/lounge where they wait for participants. Participants are escorted from their program rooms to the lounge area and their coats are retrieved by staff, who then assist with dressing them for the outdoors.

Primary program spaces

For most participants, days at Shepherd House begin in St. Francis Hall, regardless of their hall assignment. The director talks about the center's early morning routine:

ADC *Everybody starts here in St. Francis Hall. It's not a totally unfamiliar environment to them. Then the people who want to attend the daily liturgy go. When you only just have a few in the early morning, it just doesn't make economic sense to divide them up, that's really not good use of staff. We make sure to have the appropriate activities for people. They drink coffee and eat muffins. It's a nice breakfast time. Around at 9:00 a.m., the Leandra Hall people move over to their room.*

Institute *You put a lot of effort into a room specifically designed for Alzheimer and dementia people, but their entire day is not spent there. Could you comment on that?*

ADC *It's because arrival and departure times are so staggered. Some participants come as early as 7:00 and maybe it's only just one or two for an hour or so. To separate them when there are so few and to have staff in two rooms is not really good use of time. They all start here and they all end here for the same reason. Some stay until 5:00, while the first group goes home at 2:30. There's no sense in splitting staff, it's too costly.*

Of course, it would be preferable to spend the whole day in the room designed for them. But the cost is exorbitant. You are talking about people affording close to $40 a day for a 1:4 staff ratio. Most people can't afford that and we have to subsidize quite a few. There's only so much to go around. That's why there's not more adult day care--because there's no funding. We have a $400,000 deficit every year. We have to raise that money in order to provide appropriate care and so there's lots of things that I would like to be able to do.

It's important to remember the alternative for too many people is being in a nursing home where they wind up sitting all day in a corridor, with one nurse for 12 patients and that means bathing them, too. We have a 1:4 staff ratio--that's just personal care assistants and activity aides. In addition, we have bath aids, nurses and therapists. We have all these volunteers. Sometimes we have as many staff as we have participants. The care that people get here is just phenomenal, but it's tough to afford it. We do the very best we can within the limits that exist.

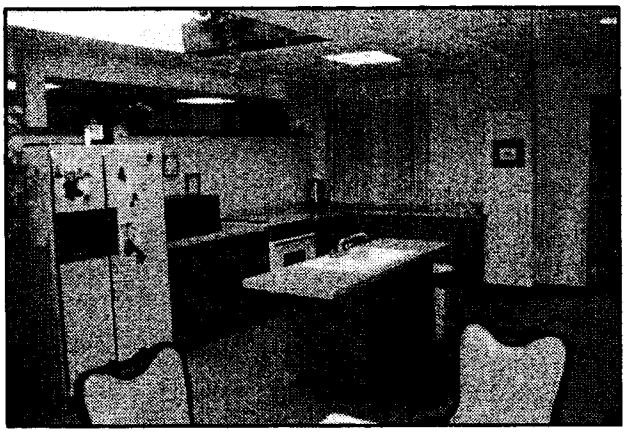
Leandra Hall is the program space intended to specifically address the needs of its population of individuals with moderate to severe dementia. The room is particularly notable for its calm and quiet atmosphere.

Leandra Hall.

Institute *If we think about the physical environment of each room, and the activities that take place there, is there anything about the rooms themselves that either help or hinder the activities that take place? For example, in Leandra Hall it seems that because it was a calmer, quieter environment it was easier for the group to stay focused and to watch the activity leader.*

ADC *A lot depends on the room arrangement. I think having seating arranged in horseshoe shape, having participants' backs to the door and refocusing them--those sorts of things give you a better chance. Also, keeping the door closed and not letting people just walk in helps.*

Eliminating clutter is important. The space should be simple. It can't look like an all purpose room, it has to look like a clearly defined living room, dining room, and kitchen. It's important to have small little meeting areas with two chairs, a table and a lamp and if someone wants to sit back there and work on a puzzle or just sit there and watch what's going on that's fine too. We need to have little separate areas, because not everyone is an extrovert, not everyone wants to be a part of all of the activities and we can't force them. They have to be able to have small little sitting areas for choice.



The open kitchen in Leandra Hall.

Kitchen and kitchen work

The kitchen in St. Francis Hall is a separate room adjacent to the room's general program space, and is furnished with square tables and chairs similar to a residential kitchen. This kitchen is used to prepare the noontime meal for all Shepherd Hall day care participants.

In contrast, the kitchen in Leandra Hall is less spatially defined, occupying a corner of the primary program space. As with most decisions relating to designing for dementia, there are advantages and disadvantages to this scheme. The director talks about the precautions that have been taken with the Leandra Hall kitchen space in consideration of its more cognitively-impaired population:

ADC *If there are any cupboards that they can open, everything in there has to be absolutely safe. All the doors that have anything injurious in them have to be locked. Everything in here has been especially designed, the stove has the controls in front and the burners are covered. The sink is out in the middle because they like to wash dishes, they like to set the tables, and they like to wash the tables down so we have square tables as opposed to round tables. They can define their own space. It has natural lighting and it's as low glare as possible, (hence) carpeting. Anything on the wall is perceived as something gentle and soft. All the flooring is all the same color. One color blends into the next, because if there's a darkened area participants feel like they are walking into a hole.*

Institute *In Leandra Hall are participants able to go in the kitchen, and into the cabinets or the sink?*

ADC *Not unless they're supervised. There's a lesser need for intensive supervision in St. Francis Hall, although they don't use the stove independently.*

Institute *Do you ever have activities, group activities such as baking?*

ADC *Yes, a lot of that. They enjoy that in both halls. They enjoy baking. Usually it's so structured so that each person is doing maybe one thing, maybe someone is stirring and someone with a little higher cognitive ability might put the things in the oven. It's broken down according to their abilities.*

Institute *It's all open but you don't necessarily want them to be using the kitchen unless they are directly supervised.*

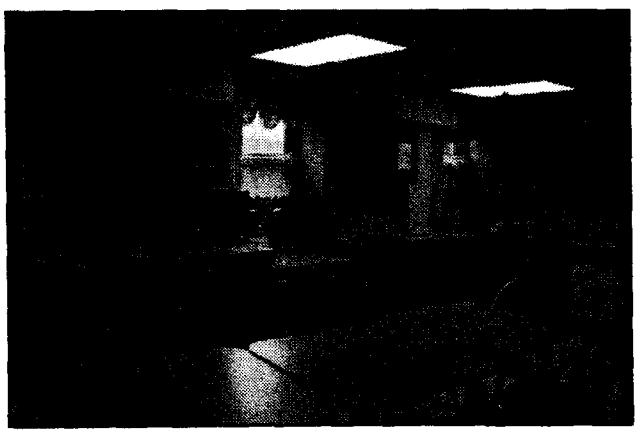
ADC *Yes, and they don't. Our people are really good about that sort of thing.*

Institute *The kitchen for St. Francis Hall, would you say that works well for those participants?*

ADC *They love it. They come in there, they sit down in the morning, drink their coffee, play cards, chew the fat. They love it. They always go right for the kitchen and sit down there.*

Institute *Considering the St. Francis Hall kitchen is used by staff for preparing meals and you have a lot of participants who are in the kitchen on a regular basis, do you have to keep the cabinets secure?*

ADC *Some cabinets do have to be locked, yes, if they're used to store implements that could be dangerous. But not all these cabinets are locked, we want our participants to be able to use this space. The participants in this room, their impairments are not to the point where they're going to pick up Kleenex and eat them. If they're that impaired, those participants are more suited to Leandra Hall. St. Francis Hall is for people who if they leave may not find their way back, but they know who they are, who can dress themselves, feed themselves. They are able to determine whether something is really truly injurious to themselves, and to stay away from those things.*



The eat-in kitchen in St. Francis Hall.

Dining

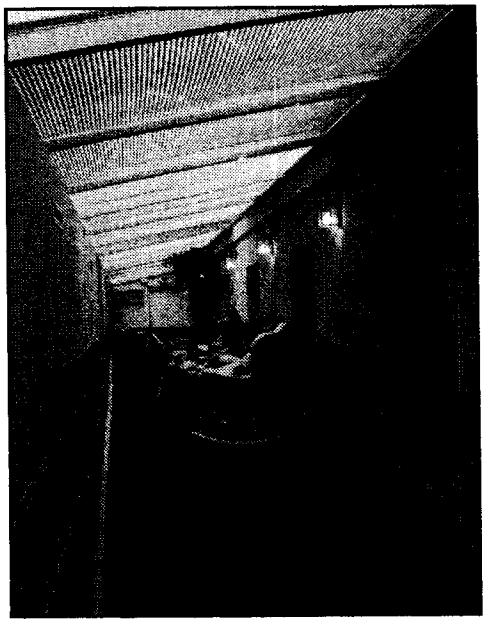
Daily, participants are served a hot noon lunch as well as snacks. In St. Francis Hall, the dining and activities areas are clearly separate. In Leandra Hall, activity tables are cleared and set for meals. Both rooms features square tables of four persons each. Most participants eat with little or no assistance from staff.

Institute *We saw lunch in both rooms and we noticed the difference in terms of the way they were served. In Leandra Hall, participants are served on regular plates and it seemed more home style. In St. Francis Hall, lunch was on trays.*

ADC *A lot of participants in St. Francis Hall are on special diets, whereas the more dementia impaired people in Leandra Hall are not necessarily on special diets. They may eat more pureed food, but not necessarily special diets. In St. Francis Hall, you have your diabetic diets, your fat-free diets, heart and coronary diets. It's very different.*

Institute *Could it also have to do with cognitive levels--you wanted the meals in Leandra Hall to be much more like home in the way that they were served, on a plate with regular silverware?*

ADC *Yes, you do, and also on square tables. That's really important.*



Natural light and places to sit in the skylit pacing corridor.

Wandering

To date, wandering among participants at Shepherd House has not been an issue. Though there is a pleasant, skylit pacing corridor located outside Leandra Hall, its narrow width and dead end do not support exploratory wandering. Activity in the pacing corridor can be viewed through the room's interior windows.

Institute *When we've observed, we didn't see many people wandering in either room. Most people were involved in an activity. Do you have many wanderers?*

ADC *Maybe a couple. We had one woman come in, she had been a practicing physician just a few years prior to her being with us, and she developed Alzheimer's disease. She paced from the moment she came in. We'd have to have one staff work with her for an hour, and then we'd have to send another staff and they'd work with her for an hour...she required all one-on-one. She was a challenge, but boy we were glad that we had this pacing corridor. She was just back and forth, back and forth.*

Institute *So you would say that the walking path is successful?*

ADC *Yes and it's nice to take them out there if they need some calming down or if they're crying or they're upset about anything, sometimes you just don't know what's going to trigger them feeling upset. It's nice to have a place that's even more calm and away from the group where you can work with them and walk with them and calm them down before they return to the group.*

Institute *If someone is a wanderer can they go out on their own?*

ADC *Yes, it's completely safe. The greens (plants in pots hung from the skylight) out there are edible, and if they eat them they won't get sick or die. There's nothing out there that's going to hurt them.*

Institute *So they don't necessarily need to have a staff person with them all the time out there?*

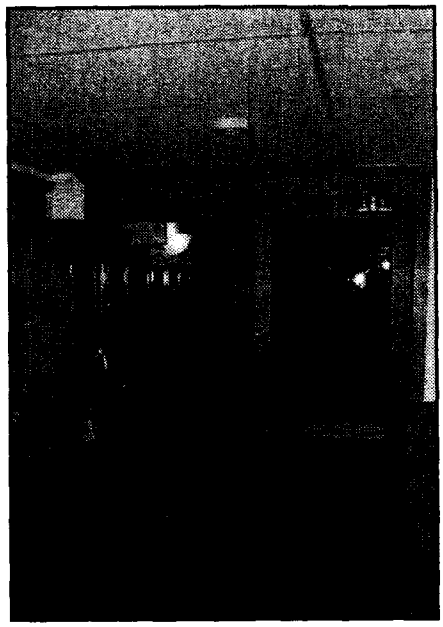
ADC *No. You can watch them through the windows if you have to.*

Institute *Do you ever have people wander the main corridor at all? We noticed that the door to the mechanical room was open at the end of the hall-- is anyone ever inspired to go back there?*

ADC *No. I can't say it's never happened, but we know when people go back there because the alarm goes off and it makes a lot of noise.*

Institute *So, nobody in St. Francis Hall is ever really inspired to wander around?*

ADC *It's fine if they do; they're not going to hurt themselves. But they generally don't. We've never had that experience with someone from St. Francis Hall, because mostly they're people with chronic physical disabilities. They have their mental faculties. If they did walk down there they might walk down, see what it is and realize it's just a basement and walk back.*



Doors at the end of the main corridor.

Elopement

Though elopement is not a significant problem at Shepherd House, Leandra Hall participants more often attempt eloping behavior. The door most often used in these attempts is located at the end of the room's laundry area, a space that is separated from the activities area by a screen wall. When not in use, this area is darkened in an effort to reduce its appeal.

Institute *Do you have a lot of people trying to get into that area, or trying to get out the door?*

ADC *Not a lot, but there's usually one. There's usually one that'll be standing around that area. So now we're trying something different. We're rearranging the living room furniture, redirecting the focus away from that area, so when they come in they'll see the attractive, soft, comfortable furniture and they'll want to just sit down. We're trying that to see if that doesn't help. We've tried all different designs. We have to address all the fire codes. We can't camouflage the doorway (per code), so we have to be really careful that it's obscured only to people with dementia, not others...that's tricky.*

Institute *You originally intended for that door not to be in view.*

ADC *I wouldn't have a door here, but we have to comply with the fire codes. If someone is going to try to go out, this is the door they want to use but everything is fully alarmed. If they do go out we gently bring them back.*

Institute *Given that the door is out of view and it's in a darkened area, is it working?*

ADC *For the most part.*

Institute *And you say for the most part because . . . ?*

ADC *There's always one or two who will see that door. They have to go across here to the bathroom. If I had my own druthers I would not have the living room across from bathroom.... But I had to work within the constraints of what I had here. It's a darker area, there is a screen there and it is alarmed, so it's never been a problem.*

Advice For Other Providers

ADC *Keep it flexible enough because you're always learning. We don't have the perfect design, we are always working within constraints and codes, which sometimes you feel are working against what you're trying to do. Keep it flexible because populations change. I never thought that we would be having adult day care specifically for people with Alzheimer's disease.*

It's amazing to think of how lucky we are to have separate facilities, let alone two levels of care. If you can keep it flexible and keep it open, you'll forever be learning things and thinking about what things didn't work and how to do things better. People are coming up with new ideas all the time. Keep the environment flexible so you can change it for the best.

In our new profound room, for example, there's going to be a strong focus on benevolent touch. The focus will be on benevolent touch, plants, growing plants, music and being entertained. There will be animals.

Institute *Can you describe benevolent touch?*

ADC *It's any positive tactile contact that's received as benevolent and given in a benevolent way. So, it could be hand holding, it could be a hand massage, for instance a one-on-one activity might be going up to someone who is sitting off by themselves where someone may sit down and say, "May I hold your hand?" They may not understand the "May I hold your hand" so you have to use non-verbal cues to communicate. We usually know that if I take that person's hand and there's a facial softening it's a good experience. And, I might take that person's hand and say, "These hands have done many things in life, these hands took care of babies, did a lot of cooking, cleaning and many wonderful things that enhanced the life of a another person," depending upon their level of understanding. Then I might give that person a hand massage so that they, perhaps on a cognitive level cannot understand or remember you, but on an energetic level they will remember that this is a safe, caring, loving person and that I am loved and cared for. So, we use a lot of benevolent touch with people with dementia. It's a very, very wonderful activity. It's the sort of new idea that we strive for.*

St. Ann Center for Intergenerational Care
St. Francis, WI

Theme
The presence of plants and children.

What this case study shows:
- The challenges associated with developing the first generation of a new idea, in this case, intergenerational care.
- Creative new ways to broaden the appeal of a an adult day care.

Place Profile

Director
Sister Edna Lonergan

Site/context
Two story building sited on a four-acre campus located on the south side of Milwaukee in a middle-income residential neighborhood

Facility type
Purpose-built intergenerational facility

Building size
Approximately 43,000 square feet. Space exclusive to elderly adult day center (program space, care areas and administrative offices): approximately 6,500 square feet.

Estimated cost/square foot
$118

Architect/designer
Architecture 2000, Milwaukee, WI

Construction completed
1998

Program

Mission and goals

The mission of St. Ann Center for Intergenerational Care is to assist frail elderly and disabled persons remain in their homes. Sponsored by the Sisters of St. Francis of Assisi, services are provided to meet the spiritual, psychological and physical needs of the people served. The Center also serves as a resource and place of respite for caregivers.

General description

Opened in January of 1999, St. Ann Center for Intergenerational Care provides day care services to three separate participant populations: children, young disabled adults and the elderly. The adult day care program provides care for frail older adults with chronic physical disease. The rehabilitative care program serves non-elderly adults with development, cognitive and physical disabilities. St. Ann's Children's Day Care provides day care for children (with and without special needs) from age six weeks through six years. Adult day care services are provided Monday through Saturday from 7:30 a.m. to 4:00 p.m.

In addition to the new intergenerational facility, St. Ann also operates Shepherd House, an adult day care program located in the basement of a convent. Since 1983, Shepherd House had been providing care for both the physically frail elderly as well as those suffering from cognitive impairments/dementia. Mary Ory, Vice President of Administration and Mary Kohnke, Vice President of Senior Adult Services and Transportation, describe the organization's philosophy and the decision process that lead to the expansion of St. Ann's scope of services:

Institute *What were the key lessons from the experience at Shepherd House and the program there that went into the program and design of the building here?*

ADC 1 *I think the first things that come to mind are the practical. We learned a lot in 15 years of running a program, relating with participants and relating with families, communicating, what worked and what might work over here. I think even though it was much smaller and much simpler, it was a good base to start from. Even in things like human resources and state regulations: over there we had learned the paperwork, and there was a lot more paperwork over here. It was overwhelming. The same state license person licensed Shepherd House and this facility, so we had learned a lot about what to do and don't do.*

Institute *Since a lot of the motivation for the new facility came from Sr. Edna, did trying to envision a new place feel like starting from scratch or were ideas--like program--carried over from the original location?*

ADC 1 *Program definitely, in terms of adults. In terms of children we had to hire knowledgeable people who could do that for us because we didn't have any experience. At Shepherd House we always invited staff members to bring their children so we always had a smattering of children in the other program, but nothing like being able to have a children's day care and dealing with all those regulations. We learned a lot about the state regulations, which are a lot tighter than they are for adults. I had heard that, but when I saw it in action it was startling.*

Institute *When Sr. Edna went to the Archbishop, did she already have the vision in mind that it would be intergenerational?*

ADC 1 *Yes, from almost the beginning...she got some flak from the board and from her own sisters because some people thought that she was going beyond her expertise in*

building a new facility, they still couldn't understand why you would include children. There were members on the board at that time who felt that we should stick with what we were good at, and that was working with older adults.

Institute *How did that become resolved?*

ADC 1 *Well, she listened, and she listens well, and there were enough people on the board who really did buy into intergenerational. It came to be seen more and more as the way of the future, where much more could be gained by bringing generations together in lots of creative ways. So over time, more and more people leant support to the notion that it was important to bring the generations together and to be able to have high school kids, preschool kids and older and younger adults as it's turning out now.*

Institute *What would you describe as the philosophy of this place? What's it all about?*

ADC 2 *To provide a home atmosphere, a social setting for adult seniors and young adults and children. Socialization for the participants and respite for the caregivers.*

Institute *How do the design and the program work together to provide socialization?*

ADC 2 *I guess it's the openness. Everyone walking by calls in and says hi. We have doors in the places where there are quiet activities, where we don't want to be disturbed, like during mass, spiritual group, perhaps during participant counsel where they need to listen and concentrate.*

The park really leads to socialization when the kids go walking through there on their walks or to their play area, and if we're out, they stop by. We've arranged our furniture to be like a living area, a social area. We kind of encourage group areas and group participation. But there are places where they can go to be on their own. They don't have to sit with the group. If they don't want to be here they can go and sit at the dining table and have a cup of coffee and not participate. No one is forced to do an activity, there's always a choice, but they are highly encouraged.

Institute *So far what would you say overall works best about this building?*

ADC 2 *I guess having the two groups of day care together, the children and the adults together in one building. I think it really encourages the participants and the staff as well to socialize. It gives them a lift during the day. Like this group of kids that was here this morning, they are the best ones to have in the morning. They are so full of energy, the two-year-olds; they get these participants rolling to start the day. They have all this energy and I think that's a good thing. Plus, here in the new space we've got more room, too.*

Fees for St. Ann Center for Intergenerational Care are $43 per day. There is an $11.50 charge per whirlpool bath. The center also offers therapy services to the community at large:

ADC 2 *We have an a la carte program and it's so people from the community can choose a service. I have a few people come in just for a bath or just for hair care, they come in just for therapy and go home. They don't have to be part of day care.*

Institute *How are these services accessed? Would people be referred by their doctors?*

ADC 2 *Yes, it's all doctor ordered, as well as the whirlpool bath. I have the doctor's health certificate signed before we do a bath. And massage is really a big thing from the outside. A lot of people from the public are using the massage therapy services.*

Following the opening of the Intergenerational Center, the plan was to continue to provide a setting and program of care specifically for the cognitively-impaired at Shepherd House, while the physically-impaired would be located in the new facility. An unanticipated issue has emerged as some cognitively-impaired participants of Shepherd House have insisted on being relocated to the Intergenerational Center, where the setting and program of care is oriented toward physical frailty and impairments.

ADC 2 *Shepherd House needs to have more participants. Everybody wants to come here. We have a lady who's returning, she's been gone for quite awhile, and she is quite confused and her daughter is insisting she comes over here. But she is not a threat of wandering, she just stays in her wheelchair, she is a fine lady and so she is going to be here. So the families...Shepherd House is really nice, but they see this building and they want their person here.*

Institute *Just to be in the new building?*

ADC 2 *Yes. We moved another guy here about two weeks ago. He was at Shepherd House. He belongs at Shepherd House. He's not a wanderer, but he's a guy who likes to pop out of his wheelchair, stand up and he doesn't lock the brakes. He's fallen at home; he's broken his hip at home and the whole bit. But it would be better for him to be in a smaller environment, a more controlled area like Shepherd House.*

Institute *Does he have dementia?*

ADC 2 *Some, due to the stroke. He doesn't have Alzheimer's disease, though he's got major depression as well. The wife, sister and daughters-in-law wanted him here and they kept insisting, so we said alright. It's working out okay.*

Staffing

The adult day care program at St. Ann Center for Intergenerational Care has a staff of 18 full and part-time employees. The ratio of staff to participants in the adult day care program is 1:5.

Participant profile

St. Ann Center for Intergenerational Care has 107 enrolled participants, a maximum capacity of 60 and an average of 41 participants a day. The average age of its participants is 78. The ethnic make-up of the population is as follows: one percent Hispanic, three percent African-American, and 96 percent Caucasian. Sixty percent are cognitively impaired, 75 percent are incontinent, and 75 percent are in wheelchairs. The gender ratio is one male to two females.

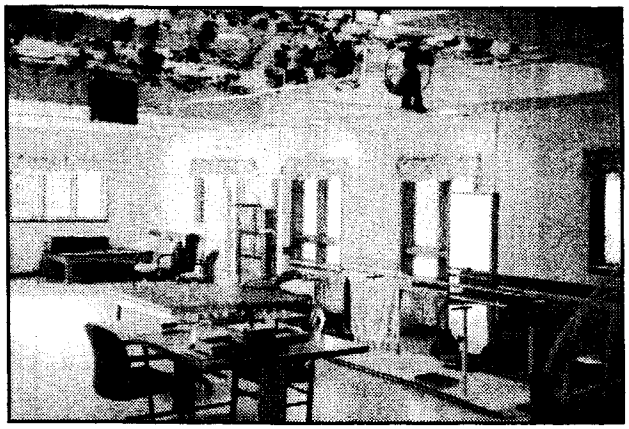
Physical Setting

St. Ann Center for Intergenerational Care is a two story building that suggests Frank Lloyd Wright's Prairie style. The exterior consists of light brick with stucco above. A taupe-colored band of concrete, a design element that is repeated beneath the second story windows and which emphasizes the building's sense of the horizontal, separates the different materials. The front entry features porte cochere with brick and stucco piers, lit via a skylight.

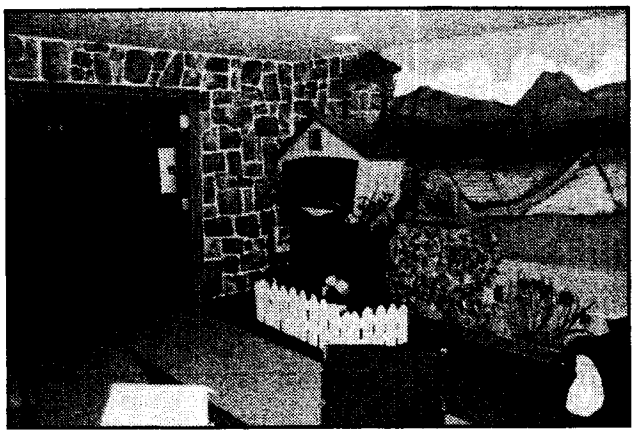
Intergenerational Courtyard as seen from exterior.

The focal point of the facility is the double height interior courtyard, which links the older adult day care/young disabled adult day care wing with the children's day care area. Other first floor spaces of the multi-use facility include the lobby, two small retail spaces, snack bar, chapel, adult day care administrative offices, older adult day care room, young disabled adult room, beauty salon, indoor swimming pool, children's day care rooms, children's day care administrative offices, service kitchen, and employee lounge.

The second floor of the facility is principally dedicated to therapy services, and includes a large physical and occupational therapy room; a whirlpool therapy room; massage, cognitive and speech therapy rooms; therapist offices, an "intergenerational" room outfitted for creative, interactive therapy activities for young and old, an ADL-training "apartment;" and general administrative offices.



View of the second floor therapy room.



Play structure in the Intergenerational Room.

One retailer offers a selection of coffee and pastries.

The description of the physical setting here is limited to the spaces dedicated to adult day care: the primary program space, entry sequence and intergenerational courtyard. The primary program space for adult day care consists of a living area, dining area and kitchen. Toilet and bathing rooms, which are shared with the young disabled adults, are located outside this primary program space.

Entering from under the porte cochere, one passes through two sets of sliding glass doors separated by an airlock. These doors are operated electronically by motion detectors.

The entry is flanked by three retail spaces that are operated by St. Ann's. One space houses children's clothing and toys for resale, the second is for costume and estate jewelry, and adjacent to the jewelry shop is a snack bar. Ory describes the concept:

ADC 1 *Practically from the time I've known her, Sr. Edna has always had this dream of having like a little mall and stores to sell important things to the participant that we attract, but that would also help defer costs, because we want to keep costs down for our participants. We don't charge our participants what it takes to provide services to them, so we've always got a deficit and we work with it through fund raising.*

Who operates those stores?

Institute

We hired a part-time person for each of the stores to oversee them. They're operated

ADC 1 *by St. Ann's, and then we have lots of volunteers.*

How are the stores working out?

Institute

The jewelry store is up and running very nicely, but see we have a long history of

ADC 1 *selling resale jewelry. When we were still in the small room at the Shepherd House area we were already collecting jewelry and selling it. We would have weekend sales at Southgate Mall when it was still busy, and we could make $3,000 or $4,000 dollars on a weekend, and that was a lot of money for us back then. That supported*

a lot of activities. So, we've been doing that for, I would guess, ten years. So it was just natural that we would take the jewelry. People from all over the world donate jewelry to us. The sisters have a lot of connections, and then our friends have a lot of connections so we get jewelry from Japan and Taiwan and all over the United States. Then we have some jewelers who volunteer to clean it up and repair some of it that is worth repairing, and we have some that's costume jewelry and then we have some very expensive pieces that have been given to us as part of estates.

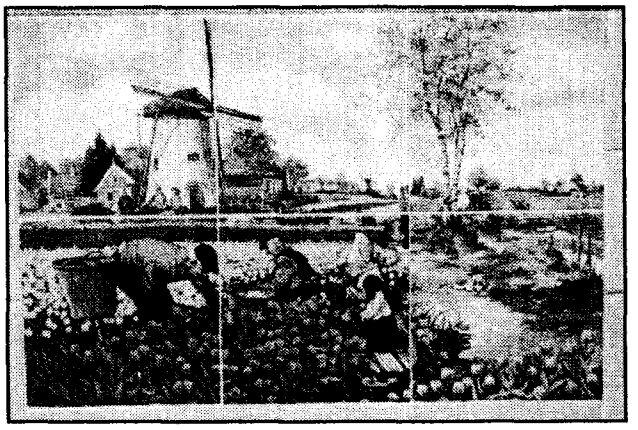
It took us longer to get the children's store set up, so it opened later than expected. The deli is just getting going, and that's another dream of hers. I think that can do quite well. We're going to have sandwiches, different coffees, teas, muffins and other things. Tim (the supervisor) is planning to do a lot of other things. I have a feeling that will do well. We have drivers who drop off the adults, and they are getting into the habit now of buying a bakery item or sandwich.... Again, it's priced reasonably, so we're not going to make a whopping profit. It is important to us, but it's not the main thing.

Across the aisle from the deli and jewelry store, the facility's receptionist is stationed behind a chest-high service counter. Visitors may be seated in the fireside lounge, a space reminiscent of a hotel lobby with floral upholstered wingback chairs, wood occasional tables and a massive fieldstone fireplace. The parquet-look vinyl floor is accented with inlaid dark and light bands, an effect that lends spatial definition to the lobby area. An open staircase winds around the fireplace, elegant with turned wood balusters and burgundy carpet runner. The lounge provides a front row seat for viewing the lush intergenerational courtyard.

Continuing along the corridor to the right is the facility's chapel, or non-denominationally, the House of Prayer. A subdued atmosphere is established with the help of the three stained glass windows custom-made by a nun associated with St. Ann's sponsoring order. Walls of the chapel are painted a deep periwinkle blue; the dense carpet is amethyst. Contradictory to the richness of color and light in the room, furnishings are sparse, consisting of two small residential style end tables and several metal and upholstered office-type stacking chairs.

The toilet and bathing rooms used by the older adult day care are located before one reaches the day care's primary program spaces. In the wing that houses both the older adult and young disabled adult care programs, there are a total of five toilet rooms and five fixtures. Plans for a sixth toilet room were modified to make way for a changing room to accommodate more disabled participants. Toilet rooms have taupe-colored ceramic tile floors and walls tiled to wainscot level; drywall above is painted white. Lighting is fluorescent. All toilet rooms are ADA compliant.

In terms of fixtures and finish, bathing rooms are characteristically institutional. Floors and walls repeat the taupe tile of the toilet rooms. White laminate undercounter cabinets provide storage.



Tile detail in a bathing room.

A special decorating touch in each bathing room is the hand-painted tile montage featuring traditional floral and rural scenes.

Continuing down the corridor of the adult wing, administrative offices are located along the outside wall of the facility while the older adult day care room abuts the courtyard. The room itself provides no visual access to the outside, although outside views are available by looking through the windows of the administrative offices. Large interior windows including an expansive bay are draped with floral fabric swags, and look out onto the Intergenerational Courtyard. A pair of French doors also provides a courtyard view. The primary program space is configured essentially as one large rectangle, one half of which is used as a living area, and arranged around a central fireplace. The second half of the space is divided into an open dining area, and an enclosed kitchen space.

In the large central living area, the working fireplace features a wood surround and mantel. The room's color scheme is comprised of burgundy, rose, pink and teal. Furnishings consist of residential-style wingback recliners, club chairs and loveseats upholstered in tasteful fabric floral prints and stripes, as well as wooden gliders with fabric cushions. This seating is typically arranged in a semi-circle around the fireplace, in front of which an activity director is typically positioned. A secondary seating area located in one corner of the room consists of a pair of Queen Anne style occasional tables and upholstered loveseats that face a large screen TV. Flooring in this central activity space is taupe carpeting. Ceilings are acoustical tile. Lighting is provided by compact fluorescent cans, supplemented by wall-mounted sconces.

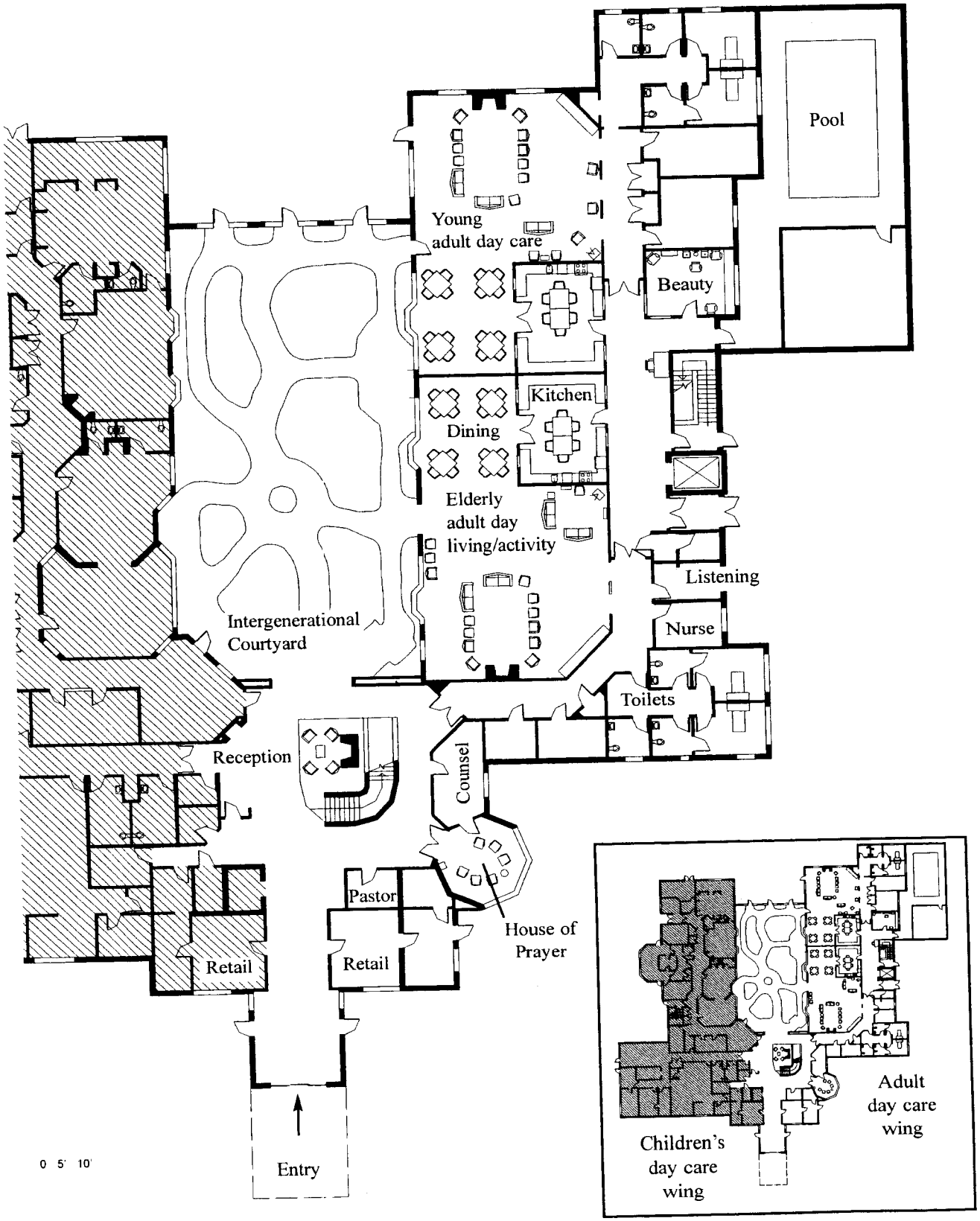
Located in one corner of the room is a long healthcare workstation of wood-look laminate. Participant files and activity props are stored in the undercounter and wall-mounted top cabinets. The dining area is spatially defined by the change in flooring material from neutral-toned carpet to light colored sheet vinyl. Furnishings consist of light toned wooden armchairs with upholstered seats and square wooden pedestal tables. A bay window to match that in the central activity area and a second window provide views of the interior courtyard. Walls are white painted drywall. Ceiling is acoustical tile and lighting provided by fluorescent cans and incandescent sconces.

The kitchen is adjacent to the dining area. Views into the kitchen space are possible through two lace-curtained interior windows as well as the glazed French doors. The kitchen has residential appliances and wood laminate cabinets, although its large size and the presence of institutional food service equipment dilute the homey feel. Arranged mid-room are a table and six chairs. Walls are white painted drywall. Vinyl flooring is continued from the dining area. The ceiling is acoustical tile interspersed with fluorescent light diffuser panels.

The heart of St. Ann's Intergenerational Center is the spacious, double height atrium, called the Intergenerational Courtyard. Opening directly into the facility's center lobby, the courtyard is the architectural element that links the elderly and disabled young adult day center areas with the children's day care area. Measuring 4,550 square feet, the courtyard contains more than 40 species of tropical plants set in raised beds amid winding concrete pathways. Interior windows and French doors provide a view onto the space from the adult day care areas.

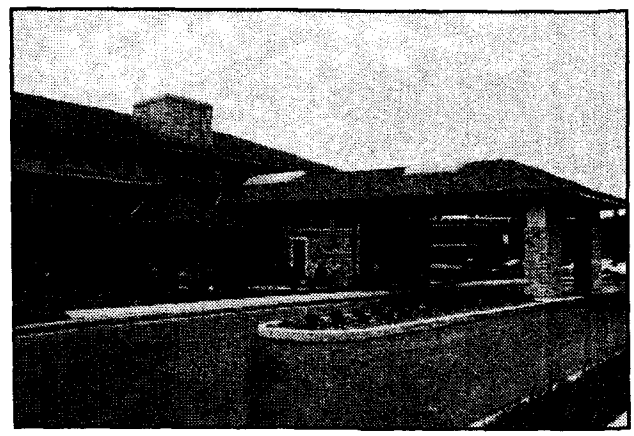
Cafe-style tables in the Intergenerational Courtyard.

Floor Plan: St. Ann's



Coming and going

Although there are several entry doors into the facility, standard procedure is for everyone to enter the building through the front entrance. Given that the program space for the older adult day care is not visible from the entrance, it's become mandatory that participants be escorted to and from the primary program space.



View of the porte cochere.

Institute *Can you describe the entry sequence for participants?*

ADC 1 *The driver brings them in as far as the reception desk, and the receptionist calls the day care room and says, "Esther is here," and then somebody from the day care staff comes out and greets Esther and takes her back to the room.*

Institute *So everyone coming into the facility comes through the front door?*

ADC 1 *Yes, that's what we envisioned, and so far it's working okay. If we open the side door, which is much closer to the adult area, then we don't have the same kind of security. Although we have monitors, it just isn't as secure as if they pass the reception desk.*

Institute *And the receptionist provides a point of security and visual surveillance?*

ADC 1 *Yes. At this point they know the participants, they know them by name and can identify them. In the afternoon I've noticed some drivers going back to the units. We know the drivers by now and so we don't really discourage that. I think it helps with a little warmer feeling between the staff and the drivers and that's always good. That's what happened at Shepherd House, and at first we thought in the new center, we are not going to have that happen, but it just seems so natural. In the mornings the drivers are busy so they want to drop them off and continue on their routes, but in the afternoons, they seems to have a little more time.*

As with most adult day programs, afternoon transitions are more harried:

Institute *How about the departure sequence?*

ADC 2 *Most of the van drivers come to our doorway and stand here. We like that better because then we can see who's here to pick up. The first group of participants starts rolling out about 2:00. After that, most pick-ups are supposed to be between 4:30*

and 5:00, but there are van companies that are late. There are a few drivers who stop at the desk, say they are here for so and so, the receptionist calls and says so and so's driver is here, we go get their coats in the closet and they go off.

Institute *The coats are at the other end of the hallway?*

ADC 2 *Yes, that's something of a problem; the coat closet is not big enough and it is far away. That could stand to be improved: and it's not large enough when you have the winter coats; it's not big enough for 35 coats.*

Institute *So when the van driver comes or when you're paged, do you take the person out in the corridor and then get their coat? Or how do you do that?*

ADC 2 *We usually do it in this front area here, right in front of the door so that we can kind of keep the hallway clear, because a lot of the vans come at once. Between 2:30 and about 3:30 sometimes we have three or four drivers here wanting their person. So it's best that they come back here and see what we're dealing with. It's not like I'm ignoring them. One of the companies we haven't used for a while, one of their problems was we didn't get their person out to them fast enough. I said they just needed to come in and see what we're dealing with. We've got to get coats, we've got to put them on and for some people it's sometimes a bit of a project to get a winter coat on. Some have boots and then we have to put on the boots. That's the process. Then the van driver takes them out to their van, and if it's a bigger group then one of our staff will go with him to make sure that he's got everyone into the van safely.*

A view of the living area and fireplace

Primary Program Space

The primary program space for the older adult day care program is essentially one large room, with the living and dining areas principally defined by the change in flooring material. Although the adult day care room's layout is a mirror image of that for the young disabled adult program, it lacks the direct exterior exposure that brightens the disabled adult day room. As a result, the overall quality of the primary program space is diminished for lack of natural light and visual access to the outdoors. Mary Kohnke remarks:

ADC 2 *I think that could have been worked out a little easier because they miss (being able to see outside). They look through my office to see what's going on outside. That's what they're doing now. At least they can do that. At Shepherd House (the program located in a convent basement), they couldn't even do that; they had to look up a window well. We always said, "What's going on in the outside world?" So that*

probably could have been worked out. They would love to be able to see outside and I think that would have been really nice. I do envy them over there (in the young disabled adult room) that they do have the outside windows.

The impression of living room is marred by the sizeable healthcare workstation anchoring one corner of the room. Undercounter and wall-mounted cabinets house participant files and activity props; day care personnel sometimes conduct charting at the long counter here. While the placement of the work station in the program space proper was to ensure staff presence in the day care room at all times, its location and size are incongruent with the original intention to create a home-like atmosphere.

Institute *The work-space cabinets in the room...you mentioned before that you wanted them in the activity room so that staff are in the room, similar to St. Francis Hall at Shepherd House, is that right?*

ADC 2 *Right. I would rather have more cupboards with doors up on the wall. There's only two and the rest are open--I would have preferred the doors. You can never have too many cabinets. We have all our cabinets jam-packed. We're having a trouble with where to put our charts; that's the big problem right now. Our charts need to be locked up and those two cabinets are all we have to lock up all these charts. All these people have a chart, and they've got to be locked up. We could have used more closed cupboard space. I like the long counter, and eventually there's a computer that's supposed to be in there.*

Institute *Your intention was to have the staff in the same room as the participants and their workspace close by. Did you consider a room adjacent to the activity room, but with a view of the participants?*

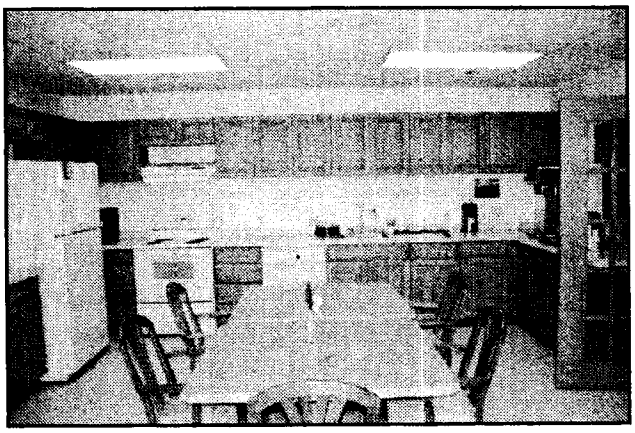
ADC 2 *No, they need to be in the room. Then you're going to get people sitting at their desk and not in with the participants. That's our main thing: You have to be with the participants. The staff needs to be with them. I'm in there a lot. I'm usually somewhere in the participant area. That's what we're paid to do, to be with the participants. You don't want to have staff sitting and working at a desk instead of doing personal cares, socialization.*

Institute *Where does the charting get done?*

ADC 2 *Most staff go to the dining room tables. Maybe a participant will sit there too, doing their handiwork. Staff can chart alongside. When walks are done and baths are done, it's hard to find time to chart, because our walk list is huge. We have a load of people on the walk list twice a day.*

Institute *If staff are encouraged to use the dining room tables to do charting and things like that, is there a need to have the counter in the activity room?*

ADC 2 *They need someplace to put their staff things. For example, I've got signs up there and we've got an attendance board up there; I wouldn't just want those sitting on a dining room table.*



Informal dining in the kitchen.

Kitchen and kitchen work

The kitchen opens onto the dining area. Although interior windows and two pairs of French doors offer a view into the kitchen, these are oriented toward the dining room and central hallway. This configuration, while it ensures plenty of cabinet space in the kitchen, has resulted in one long blank wall facing the central activity area and accordingly a lack of visual access to the primary program area.

Institute *How would you compare this kitchen with the kitchen at St. Francis Hall (at Shepherd House)? Were there aspects of that kitchen that you wanted to see here?*

ADC 2 *The cupboard areas. We had quite a few cupboards in St. Francis Hall kitchen, so that was replicated. With this kitchen something I would have preferred--I wish I would have thought of it before--is having a window on this wall. If we're in the kitchen you can't see what's going on out here. There may be two staff people in the room, on unit, but they don't know what's going on out here. You've got to be able to see this room.*

Institute *In other ways does the kitchen work well?*

ADC 2 *It's fine--a lot of counters, cupboard space. It's great other than the lack of a window into the unit. From the other side, too, they can't see from the room into the kitchen.*

Meals for the older adult day care program are prepared in the center's commercial kitchen and plated in the day care kitchen. As a result, the kitchen was designed with eat-in space, accommodating a table and chairs for six.

Institute *Do you have enough counter space? Is it efficient for staff to get food out?*

ADC 2 *Yes. Although I should say that when the kitchen carts are in there for serving, it gets a little crowded. We've got participants around the table. The kitchen could have been bigger too. It looks big, but I think that now we've used it and seen how much space wheelchairs and those kitchen carts take up, we could have used a bigger kitchen.*

Institute *That's an interesting comment considering your experience. You came from the basement of a convent where you had not a larger kitchen, but a more open kitchen there. Here it's a more enclosed kitchen. Was it intentional to have a more fully enclosed kitchen in this building?*

ADC 2 *It wasn't intentional. It was just the architect's design.*

Dining

Participants at St. Ann's are served a hot noon lunch as well as snacks. Eating activities take place at the four-person square pedestal tables of four each. Most participants require little or no assistance with eating.

A view to the dining area from the living room.

Throughout the day, the dining area serves as a space that is available to participants who wish to observe activity rather than participate. Occasionally, two or three participants will be engaged in a small, directed group activity (cards, handiwork) with a staff person or volunteer in the dining area, while the majority of the group involved in another programmed activity (for example, a physical exercise session).

Toileting

The adult wing of St. Ann's Center for Intergenerational Care contains five toilet rooms and five fixtures, all of which are located outside the primary program space off the wing's central hallway. Two are located toward the young disabled adult room; three are near the older adult day care room.

A sixth toilet room for the wing was modified as a changing room for attending to the toileting needs of participants unable to stand. Mary Kohnke explains:

ADC 2 *We took one away and made a changing room for people who can't stand. With those participants, we have to get them onto a table. We have a hydraulic lift massage table that we adjust to the height of the wheelchair, and then sometimes it's just a slide over. That was a real need. It would have been nicer to have that changing table plus three bathrooms (at the older adult end of the wing). You can never have enough bathrooms, because participants go to the bathroom a lot. You can never have enough. We could probably have used more.*

Institute *Do you ever have a wait?*

ADC 2 *Oh yes. Everyday there's a couple of people who stand right there. To them we say, "You've got the next ticket."*

Institute *Is one staff person always doing some kind of toileting?*

ADC 2 *Yes. Right at this doorway there's always one person directing the traffic of the bathroom. After lunch. As soon as they put down their fork they want the bathroom.*

Institute *What's the process?*

ADC 2 *Some of them forget that it might be crowded and they just kind of walk up. We tell them, "You've got to wait. It's a full house." It's better they would wait in here (the main activity room) than in the hallway. They start drifting out there. We had that at Shepherd House as well. We could have used more bathrooms; we never have enough bathrooms.*

The location of the toilets, outside of primary program space and down the central hallway, has proven problematic:

ADC 2 *...even though our dementia participants are over in Shepherd House, our participants here still lose their way.*

Institute *So staff often have to lead participants to the bathroom?*

ADC 2 *Yes.*

Institute *The majority of them?*

ADC 2 *Yes, everybody. We watch them as they go. The majority of them, I think, can go alone, but we stand by this doorway here and watch that they get back. We figure they got into that area, but can they get back?*

Institute *Would you have preferred that the bathrooms were closer or more adjacent to the activity room rather than down the hall?*

ADC 2 *This is fine.*

Institute *Even though some people don't know where it is?*

ADC 2 *I prefer that the bathrooms not be right through the door of the activity room. I like it away a little bit because then you don't hear all that noise.*

Institute *So for noise reasons you think the current location is good?*

ADC 2 *Yes, you don't hear all that flushing. These new tanks are loud. We don't hear that over here. And the tub rooms are there too, and we don't hear all that. So I like the noise factor that it's a little bit away, not far, just a tad away.*

Institute *Was it purposeful for the toilet and bathing area to have exterior exposure, have them have access to the windows?*

ADC 2 *That's the way it happened. We can open the windows in the bathing areas when the baths are done. The seniors are most of the time cold, so we can't open those windows during baths. There will be air conditioning so that wasn't a necessity to have those or to have open windows. After baths are done we can open them to get rid of the humidity, but it's not a necessity, it happened that way.*

Wandering and elopement

Given that most participants at St. Ann's Intergenerational Center are physically frail and mobility-impaired, dementia-related wandering and elopement have not been issues to date.

Courtyard space

The heart of St. Ann's Intergenerational Center is the Intergenerational Courtyard. Opening directly into the facility's center lobby, the courtyard is the architectural element that links the senior and disabled young adult day care areas with the children's day care area. Concrete pathways wind through raised beds of tropical and native plants, life-sized garden statues, small café-style tables and chairs, garden benches, a full-size gazebo and novelty play areas for the children.

Interior view of the courtyard.

Institute *In planning for this building, what was the intent of the courtyard?*

ADC 1 *I know it was to be like the hub, the center, the gathering place. The place where people could go to be alone or play or to be with a group. I think it was intended as a way of drawing participants and staff closer to nature all year round, in a way that we wouldn't have to worry about the elements. With the courtyard, we wouldn't have to be concerned as to whether or not the children could go out and play and whether or not the adults could watch them play and whether or not the adults could join them.*

While interior windows and a set of French doors provide visual and physical access from the adult day care room into the courtyard, the lushness of the plantings, which includes tall, leafy palm trees, impedes visibility of the courtyard from the primary program space:

ADC 2 *When we first moved in there was too much foliage. They did weed out quite a bit of it. It was like a jungle when we first got over here. They weeded it and they had to take out some toxic plants that were in there, and with a children's day care, you can't have that. So the kids couldn't even go out there until they got rid of the toxic plants. I like it better now that it's been thinned out....*

Institute *Is the fact that it opens into the lobby a concern to you?*

ADC 2 *It's worrying to think of letting people out there alone and having them getting lost or going out the front door and who knows where, not that they're lost, but they're going to investigate something. Otherwise I like it, I like the open part of it. We sit out there with late people, with participants who get picked up late. We enjoy the time out there. It's a change of scenery.*

Advice For Other Providers

Institute *What lessons do you think you've learned having gone through the process of creating a visionary facility that would be useful for other day care professionals?*

ADC 2 *I know one is don't move in before things are in place...get organized. We had furniture delivered when we were here with participants; we didn't have enough and I wouldn't do that. Not everything has to be here, you don't need to have pictures on the walls, but you need the necessities. You've got to have time to organize it, get the staff over here and set it up. It takes a lot of planning and a lot of meetings and so many changes.*

You can't just have somebody like the architect deciding all this stuff, because they don't live day care, they haven't lived with it. Like the kitchen; I was in on designing that kitchen. You've got to have someone who's lived it and who works in it. That's why the whole staff was in on it. I would ask my staff all the time: What do you think about this, what would you suggest? I always had my staff involved. And that's good too, good for morale that they all had a say.

Institute *In terms of the physical plant, what do you think is absolutely essential to a good day care?*

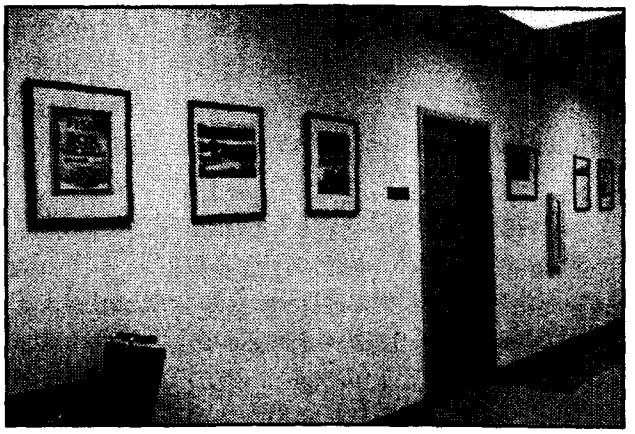
ADC 2 *A decent air exchange system. Windows--to be able to look outside and know what's going on out there--is very essential. And space, you can never have enough storage space. You can never have enough cupboards, bathrooms, and closet space.*

Alzheimer's Family Care Center
Chicago, IL

Theme
Do not disturb.

What this case study shows:

· The advantages and disadvantages of a highly-segmented approach to dementia day care.
· The implications for the physical setting of a program that emphasizes modulating environmental stimuli to match the needs of different participant groups.



Place Profile

Director
Jane Stansell

Site/context
The remodeled commercial building is situated on the east side of a busy thoroughfare in Chicago, which is lined primarily with commercial shops and offices. To the north and east of the Alzheimer's Family Care Center (AFCC) is a residential neighborhood consisting of two-story frame houses, a large Catholic church and a school.

Facility type
Adaptive reuse of a commercial building

Building size
Day care alone: 9,000
Building total: 11,500 square feet

Estimated cost of renovation
$600,000

Architect/designer
Eckenhoff Saunders, Chicago, IL

Program

Mission and goals

According to Director Stansell, the mission of the AFCC is "managing many of the complications of dementia, improving the quality of life of the person with the illness and lightening the families' burdens. The Alzheimer's Family Care Center assists its participants and their families throughout the course of the disease in dealing with the intellectual decline and increasing dependency that characterizes the disease."

General description

AFCC is a not-for-profit organization under the direction of a general sponsoring authority, Rush Presbyterian-St. Luke's Medical Center. The organization provides day care services to a daily average of 55 older adults experiencing varying types and levels of cognitive impairment. Key to the day care programming at AFCC is the concept of participant groups: participants are segregated by interest and abilities and assigned to specialized units, i.e. the music room group, the hobby shop group, the parlor group, and the recreation group. This ability and interest-based approach toward adult day center was developed over time by AFCC.

Established in 1987, AFCC originally provided adult day care services in a large single room located within the Irish American Center in Chicago. Soon after, staff perceived that this single undifferentiated area seemed to exacerbate difficulties in caring for the cognitively impaired, a consequence of the diversity and heterogeneity of dementia sufferers.

Two years later, AFCC moved to a residential home where they initiated the policy of dividing the population into three participant groups on the basis of a subjective assessment of attention span, and then caring for these groups in different areas within the home. Eventually, these groups would come to be recast in terms of exhibited strengths and weaknesses. After two years in this residential location, the organization determined that the environment was restricting their ability to establish the intended therapeutic setting. Three primary shortcomings were identified: accessibility problems resulting from serving one participant group in the basement of the house; having only one toilet; and an administrative sense that participants could well be divided into more than three ability groups. Given their unique programming approach and experience with adult day care, AFCC initiated planning and development for the new facility.

Today in their newest facility, AFCC's program has settled on seven spaces used by four explicit participant groups. The music room group--made up of the most functionally able participants--typically consists of 20 participants attended by one staff member. Their activities take place in four different rooms: the dining room, the living room, the den and the music room. Three other groups of lower and varied functional abilities--the hobby shop group, the parlor group, and the recreation room group--stay throughout the day in the room for which they are named.

The participants of AFCC's largest participant subset, the music room group, can communicate effectively, perform activities of daily living (ADLs) with minimal verbal and visual cues, and engage in "hands on" activities. Hobby shop group participants can communicate verbally and/or non-verbally and perform a variety of "hands on" tasks, but require some cueing for ADLs as well as structure and reassurance to cope with their high levels of anxiety. Parlor participants have the same skill level as those in the hobby shop, but are more sensitive to overstimulation and require greater assistance with ADLs. The parlor is intended to provide a calm, quiet, slow-paced environment with modulated sensory stimulation and activities that highlight gross motor movements. Recreation room participants typically communicate non-verbally, are physically active and interested in exploring and interacting with the environment, and require assistance with all ADLs.

AFCC provides services to its participants and their families from 7:00 a.m. to 5:30 p.m. Monday through Friday. Services at AFCC are provided based on participant needs and in accordance with

financial and staffing constraints. No counseling, clinical services or physical/speech/occupational therapies are provided. Services offered include:

- A light breakfast (i.e. toaster pancakes or pastries)
- A hot noontime meal
- Afternoon snack
- Activities (i.e. bingo, crafts, music);
- Personal care (i.e. toileting, medication);
- Care planning, and
- A family support group

These daily activities are carried out independently within each participant group, with each group following different care and activity plans depending upon participant abilities. This approach to programming results in several activities being simultaneously conducted throughout the day; however, given that participants are assigned to particular groups and settings, there is little sampling by participants of the different activities that are taking place. AFCC's day rate is $45.

Staffing

AFCC has 17 employees, all whom have some degree of direct contact with participants and provision of services. Three people make up the organization's administration: the program director, clinical coordinator and financial coordinator. Providing guidance to AFCC administration is a 10-member advisory committee comprised of professionals in aging and clinical practice. The staff takes turns developing the activity programming and giving staff assignments on a round-robin basis. In effect, this allows for planning and administrating responsibilities to be shared among all staff members. Weekly staff meetings are scheduled to review care plans, scheduling issues and the like. AFCC has been successful in supplementing staff with volunteer support, typically receiving an average of 10 total volunteer hours per week.

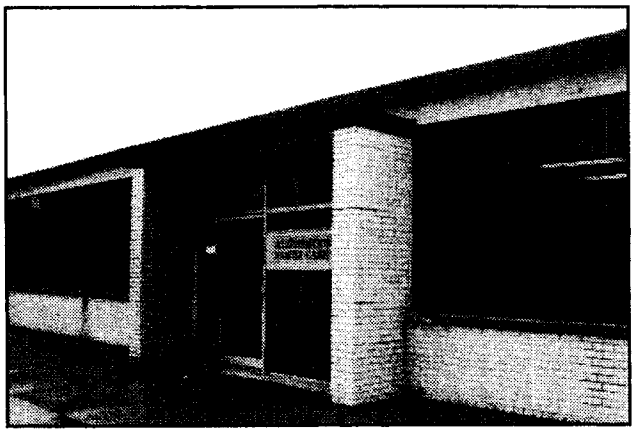
Participant Profile

AFCC has an enrollment of 94 participants and an average daily census of 55. Its service area stretches from the southside of Chicago into Southern Wisconsin. Geo-economic profiles range from Northwest Chicago blue-collar to Northern suburban professionals. Participants range from 38 to 97 years old, with an average age of 80. Approximately 75 percent of the participants are white, 14 percent are African American. One-third of participants are Medicaid-eligible. All participants of AFCC are cognitively impaired, with an average MMSE score of eight (maximum = 30). Eight percent of participants use wheelchairs, and 60 percent are incontinent.

Institute *Have families mentioned a willingness to be involved in activities?*

ADC *Yes, but we discourage it because families need a break. I know there are places and there are programs where families are involved almost on a daily basis, and that's a good thing in some ways depending on how it's done. I've also seen (places) where families are used almost as staff. What we prefer to see people do is volunteer somewhere else, to have a change in focus. You don't need to be living Alzheimer caregiving 24 hours a day.*

Physical Setting



Entry to the facility.

AFCC's building is a square, single story structure with masonry bearing walls and a steel truss roof. The exterior is primarily brick and concrete block and features a continuous mullion window system with painted metal frames. The facility's entrance consists of a single door with glazed sidelights. In addition to this door, there are two others through which one must pass to reach the main corridor of the facility. The third door utilizes one of the City of Chicago's approved exit alarms--the door does not open for 19 seconds.

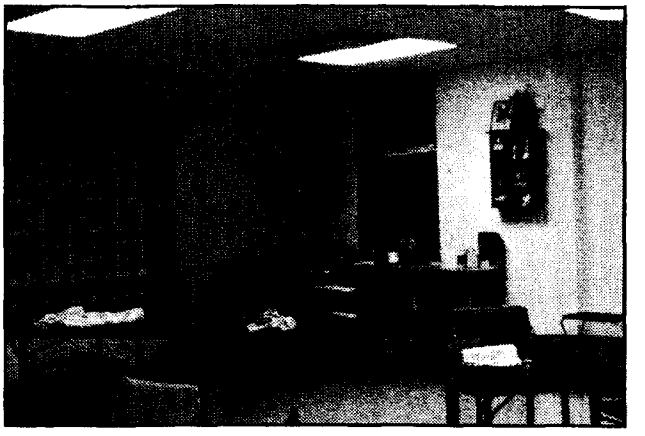
The interior layout of AFCC is organized around a convoluted "figure-eight" type corridor scheme that connects the program spaces. Once inside, one sees two long, undifferentiated corridors. To the right is the receptionist's office where staff on "door duty" await visitors and arriving/departing participants. The intersection of these two corridors is often congested, with participants waiting in the nearby chairs, staff waiting to assist participants, and others checking their mailboxes or retrieving office supplies.

A view of the main corridor.

Ceilings throughout the facility are dropped acoustical tile with fluorescent light fixtures. Interior partitions consist of either painted concrete block bearing walls or painted gypsum board. Floors throughout the participant spaces are glossy vinyl tile. Each participant space has a single entry door with a window-like vision panel, although the window is typically shuttered by a corridor-side blind.

There are a total of eight participant areas in the facility; the four participant groups regularly use seven. These areas comprise the living room, dining room, music room, recreation room, parlor, hobby shop, den and sun room.

The living room and den are essentially duplicates of each other, and furnished with approximately 20 chairs lining the perimeter of each space. These rooms are typically used for discussion groups, exercise and word games.

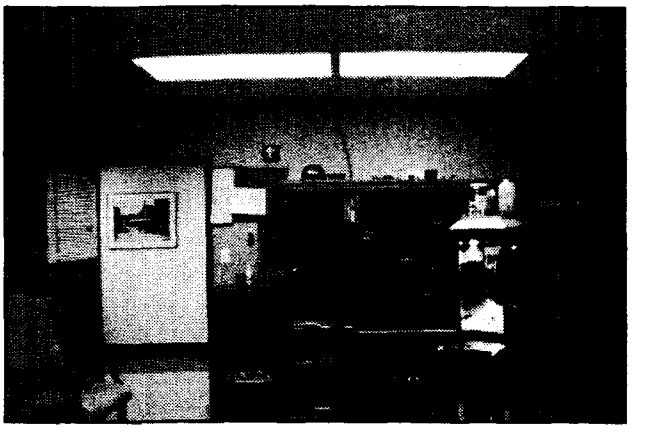


A corner for quiet activity.

The music room and dining room are mirror images, both furnished with round tables and chairs arranged around them. The music room is used for breakfast and lunch as well as for bingo in the late afternoon, while the dining room is primarily used for crafts.

The recreation room is an internal room with no visual access to the outside. The door into the room remains closed at all times. This room is the largest space in the facility (approximately 800 square feet) but serves the fewest participants, with an average daily census of six. There are various pieces of furniture in the room (i.e., tables, piano, and desk) as well as a custom cabinet that serves as a staff workstation. The walls have little decoration.

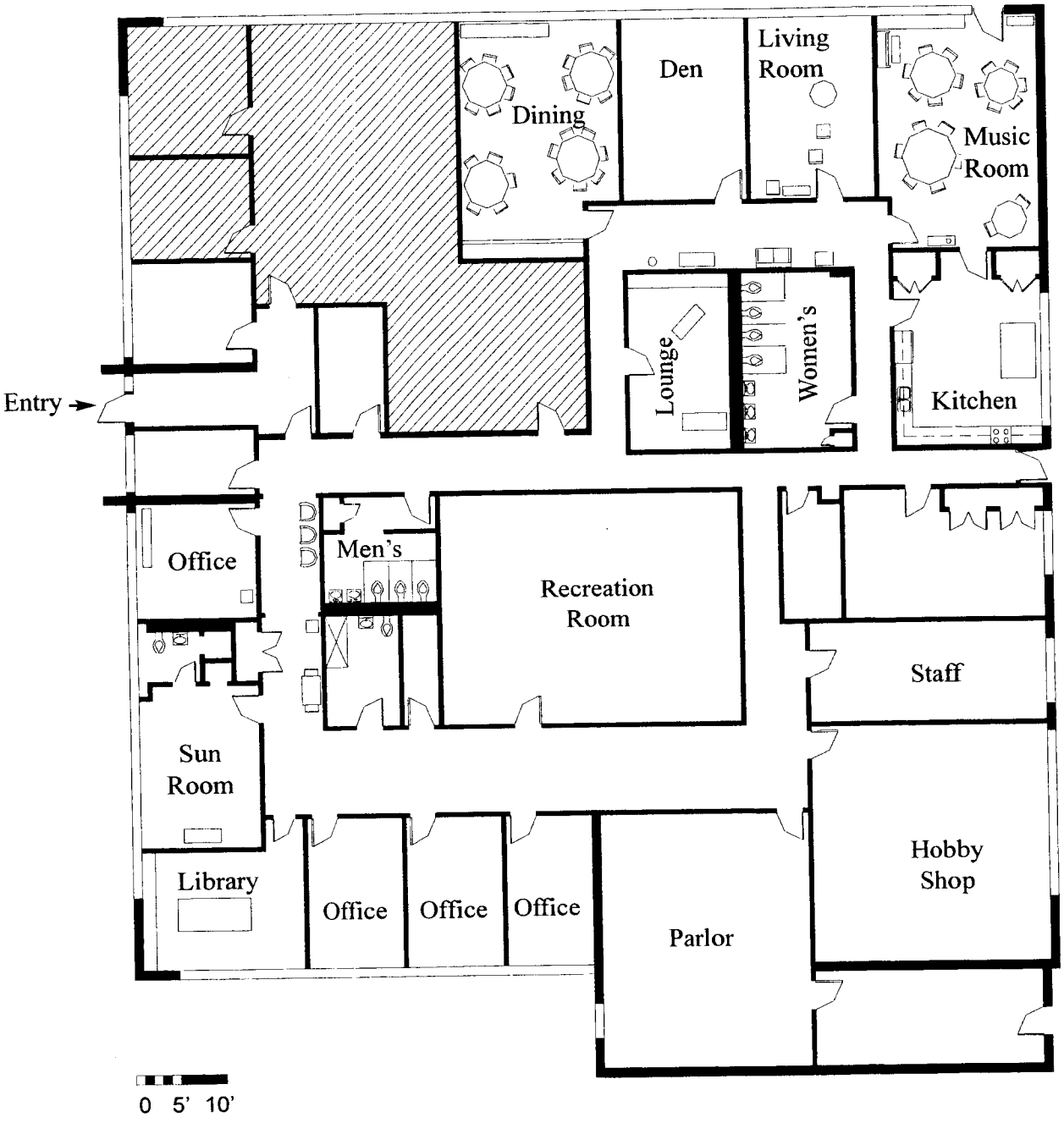
The parlor is designed as the "low stimulation room." There is a small window that looks out into the courtyard of the facility, but the window blind remains closed. Many items are displayed in the parlor: games and magazines on shelves by the window; purses and scarves on the pegboard; and laundry baskets of craft materials piled against a wall.



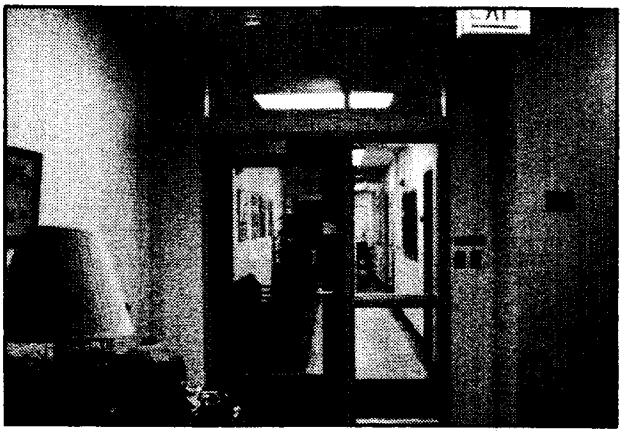
A popcorn machine located in the den provides a welcome snack.

The hobby shop is the one room that provides setting options for participants. Available for participant use are office-type cubicles, three round tables and a five-chair discussion area set up in a corner. Many items are out for participants to touch and use: craft material along shelves; old cameras and electronics; and books and magazines. This room has east-facing windows fitted with blinds. This is the one room in the facility that requires daily intervention to maintain thermal comfort, i.e. window ventilation and blinds to regulate sunlight.

Floor Plan: AFCC



Coming and going



Reception area and entry corridor.

Arrivals begin around 7:00 a.m. with most occurring between 8:30 and 10:00. Upon arriving, participant coats and hats are removed by staff in the corridor; the arrival of several participants creates a bottleneck in the hall space directly in front of the entry as participants wait for others to be assisted. This bottleneck is exacerbated as other vehicles pull up to unload participants. In an effort to alleviate the crowding, participants may wait up to 20 minutes in the van while others are taken into the facility one by one. This sort of delay happens even more frequently during departures.

Many participants were observed as unable to find their way from the entrance to their assigned rooms, so staff lead them through the internal corridors to the appropriate area.

Institute *Do you think the lack of outside visual access from the corridor impedes participants' abilities to find their way around?*

ADC *No, certainly not. Why? If you don't know where you are and you don't know how to get home and you know that you've got to get there, what is your prime concern? Getting home. Now if every room had visual access to the outside, that would just increase that anxiety.*

Depending upon the length of their van trip, participants may also request a bathroom stop enroute to their assigned room. Once in their assigned room, participants are greeted and offered coffee. From van to cup of coffee, the arrival sequence can take a half-hour or more to complete.

Departures begin around 3:00 p.m. and continue until 5:30, with most participants gone by 4:30. Those that wait until 5:30 usually are engaged in bingo, but seem to be preoccupied with leaving. The front-entry bottlenecking experienced in the morning is repeated, often exacerbated by wanderers who congregate by the front door.

The sequence of departure is initiated by a van driver or family member coming to the front door and requesting their riders. Front staff intercoms appropriate room staff to call for the participant(s). Each time this call comes into a room, nearly all participants were heard wondering aloud whether the call related to them. Participants were often observed trying to follow those departing, prompting staff intervention.

Because van arrival is somewhat informal, it is difficult for staff to assemble van-mates ahead of time. Collecting and dressing other participants for departure often entails long waits for those who are readied first. Coincidentally, departure marks an occasion for toileting most participants. Often this delays the departure process as well.

A view of the living room.

Primary program spaces

In their facility development process, the staff of AFCC devoted a great deal of effort to space planning and room names. The notion that places have meaning was recognized and they endeavored to capitalize on that idea for the therapeutic enrichment of the new facility. Current literature in the field of architectural design for dementia advocates residential flavor, thus the room names at AFCC are associated with "home." There is a living room, dining room, music room and den. These spaces are used by the most able. The hobby shop is for those who need an outlet for their energy. The parlor is reserved for those who require a quieter place, and the recreation room is for the most physically active. While the link between place names and the environmental qualities AFCC desired to instill in these spaces is creative, the "follow-through" in terms of architectural and interior design is less effective. Few of the spaces look, or more importantly, "feel" like their place names and therefore don't achieve the desired qualities.

As mentioned in the general description of the program, AFCC's program strategy dictates different activities for each space and participant group. For all participant groups, the first formal activity of the day begins around 10:00 a.m., and there is a general mix of cognitive and physical activities through the day. The final activity of the day, bingo, is scheduled for those "late-staying" participants from all four groups who are gathered together in the music room.

The group with the most intact level of skills, the music room group, uses four rooms throughout the day--the music room, the dining room, the living room and den. Typically, the music room is the most-utilized space for this participant group, with the living room used somewhat less and the other two rooms rather sporadically. The music room is the place for meals and snacks, bingo at the end of the day, and the occasional discussion group. The living room is used for cognitive activities and social groups. The den hosts some discussions and is also the site for evening family group sessions. Inconsistent with its name, the dining room is used primarily for craft activities.

As a rule, the three less functionally able participant groups spend their entire days in the rooms for which they are named. In the hobby shop, there are three distinct sub-settings: three round tables for focused activity (puzzles, eating); a sitting corner for socializing and exercise; and two carrels and a desk for individual activities. Notably, this participant group exhibits the most initiation, although they are characterized as having the highest level of anxiety.

Interestingly, the center's clinical coordinator considers the hobby shop room as having the greatest correspondence between space and participant group ability.

The parlor is the designated space for individuals deemed sensitive to overstimulation and who require greater assistance with ADLs. This census is kept quite low (typically six to eight) and not much activity occurs in this room. Sometimes a card game or a board game will be played, but the pace of life in this room is quite slow. Due to the low level of stimulation, any entry to or exit from the space attracts the attention of participants.

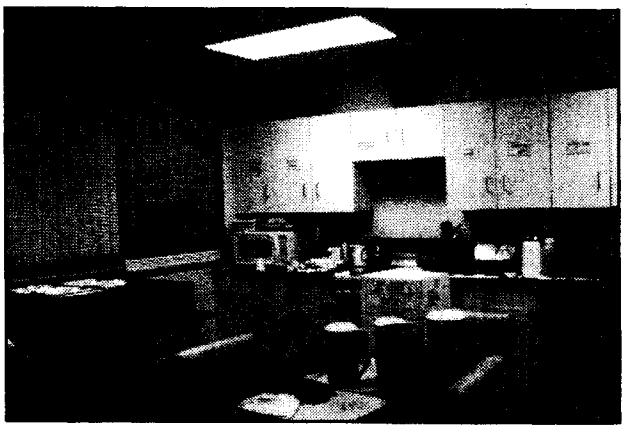
The recreation room houses the non-verbal, physically-active participants. Despite it being the facility's largest room, the census is kept to a handful of participants in a effort to provide adequate room for physical activity. This room provides no outside visual access. "Stations," for example, a piano, desk, washing machine, bookcase, line the perimeter of the wall to engage participants. Researcher observations suggest this participant group exhibited the greatest amount of agitation and physically abusive behavior.

Kitchen and kitchen work

The kitchen at AFCC is used almost exclusively by staff for the purpose of preparing lunch for 50-75 people. There is little of the ambience of a home kitchen and staff usually discourage participants from entering the kitchen.

The hobby shop.

The parlor.

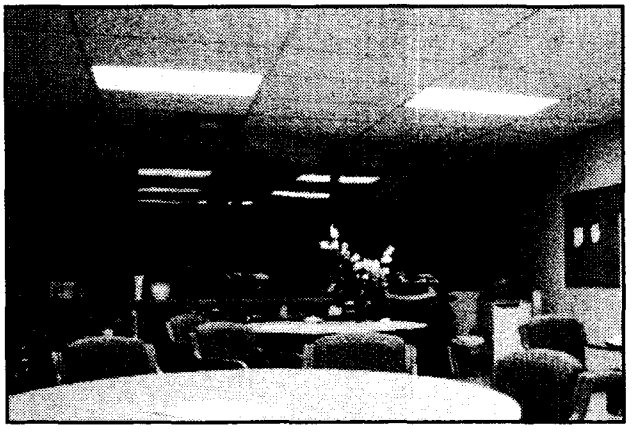


The kitchen.

Institute *You mentioned that activities generally need to be initiated, but among the more competent group, are there people who express their willingness to do something in the kitchen or use the kitchen?*

ADC *Sometimes. Do we have cooking activities? Yes. Do we do all of those in the kitchen? No. Why not? 'Cause there "ain't" room. You can't have a group of 15*

people or 10 people in the kitchen that's not big enough, so we have cooking activities that don't occur in the kitchen. There are folks who would like to help in the kitchen that we discourage from doing that because they are diabetics and they would eat everything in sight that is not tacked down...their families don't let them help fix dinner at home either.



The dining room.

Dining

With the exception of the music room group, participants eat lunch in their respective program rooms. For music room participants, the routine is natural: they proceed from their activity in the den to find tables set and their salads awaiting them. Participants are seated and beverage orders are taken.

The lunchtime experience in the other rooms is quite different. Often a program activity will be interrupted by the arrival of the food cart, at which point participants are asked to relocate as tables are cleared and set for dining. At other times, participants sit and wait at the tables for extended periods of time as food arrival times can be variable.

Bathing

At AFCC, each participant's personal care is attended to individually depending on abilities. Some individuals are toileted every two hours with prompting and assistance by staff; others are completely independent. Personal care activities like hand-lotioning and nail care are here conceptualized as therapeutic activities. Care planning occurs in weekly staff meetings where individualized care plans are reviewed.

Although AFCC's facility has two showers (no bathing tubs), officially, the organization does not provide bathing services. A shower original to the building is located adjacent to the sun room, a space that is not utilized by the program. During remodeling, a second shower was installed in the handcapped-accessible toilet room. However, because of the frequency of the use of the handicapped toilet, use of this shower is negligible.

ADC *We have two showers in the building, but the one is very difficult to use because of the arrangement of it. It was there when we moved in and we left it. We've used it a couple of times, but it's very difficult to use. The one that we built is very easy to use, but it ties up the bathroom too much. I wish we had another of those...*

Institute *Have families expressed a desire to have bathing service?*

ADC *I think for a number of people that would be a helpful service. That's a real mistake we made when we renovated this building. We put the shower and the handicapped bathroom in one room, and we probably should have done two rooms, because it takes us a half-hour or forty-five minutes to an hour to give someone a shower. We thought when we were putting in this shower that we were going to start offering that service. We were too dumb to realize that it would tie that bathroom up too much and we need that bathroom on this side of the building. So we don't offer it because it would tie the bathroom up too much. We shower people when there's a need, but it's not an ongoing service. If I had been smarter and brighter when we renovated I would have put in a shower in a room separate from the handicapped toilet.*

Toileting

AFCC has four toilet rooms and a total of nine fixtures. Two toilet rooms contain one fixture, one of which is handicapped-accessible. Two additional rooms have ganged stalls. These toilet rooms remain in their original state (pre-AFCC remodel). As they are of standard size, the toilet stalls allow little room for movement, and the ganged toilets have become awkward as the population has increased its need over time for assistance with toileting. In addition, the location of the toilets in relation to the program rooms has proven problematic: Many participants require assistance in being lead to the toilet rooms.

ADC *(If I could) I would have at least two handicap accessible bathrooms instead of one. One that's large enough for two person assists. Lately we've had a lot of two person assists. In fact in January we had three participants needed three people to toilet, two people to assist in the transfer and one to clean their bottom because you couldn't do that while you're holding them during the transfer. So I would have two bathrooms. If I could have done this anyway I wanted, I think that in some rooms I would have the bathroom in the activity room, particularly for the parlor and the rec room....*

Institute *Are there difficulties for participants in finding the restrooms?*

ADC *Oh sure, absolutely, no question about it. Even if we had signs everywhere, there would still be problems. People have difficulty finding the bathroom at home when it's next to the bedroom and they've lived there for 30 years. I firmly believe that wayfinding is a real issue in terms of the bathroom, and I think that not being able to find the bathroom is a real cause of incontinence in some people. Short of having bathrooms open so that everybody can see in there at all times, I really don't know what the answers are. When we have the sun room open (there is a bathroom in the sun room), you can leave the door open and people can see it. That doesn't mean that they can connect that it's a bathroom though.*

A long view of the corridor.

Wandering and Elopement

At AFCC, wandering takes place in the facility's main corridor. The layout of the corridor is confusing and difficult to discern for even competent individuals. There are no memorable orienting devices or landmarks along this corridor. The only marker on the wandering loop is the front door, which is, unfortunately, a feature that typically increases agitation and cues elopement desires. Together, the general lack of stimulation along the corridor and the attraction of the front door confound pacing behavior.

Advice For Other Providers

Institute *What do you like best about your facility?*

ADC *I like having different spaces that support peoples' strengths. Like the rec room has room to move and people can move around without distressing or disturbing other people in the group. There's room for exploration and so on, and I like that a lot.*

Institute *From your experience with facility development, what should others watch out for?*

ADC *Pay attention to what things are going to cost over time. These can be far more important than original costs. It's too easy to get caught up in immediate cost. When you're building something that you have to go out to get philanthropy to cover, and every dime you spend you've got to raise, you try to keep the cost as low as possible. But sometimes the less expensive option will cost you more over time, or will cost you in other ways you might not have thought of.*

Epilogue

Shortly before this monograph went to press, we were informed of the closure of the Kiel Adult Day Center in Kiel, Wisconsin, due to low enrollment. It was with great regret that we received this news. While we are mindful of the economic forces and economies of scale that can impact emerging and specialized services such as adult day care. In many ways, the program at Kiel represented the essence of adult day care quality. It is our greatest hope that the same sensibility of dignified, individualized care in a familiar setting will not be lost as the field of adult day services continues to develop in the future.