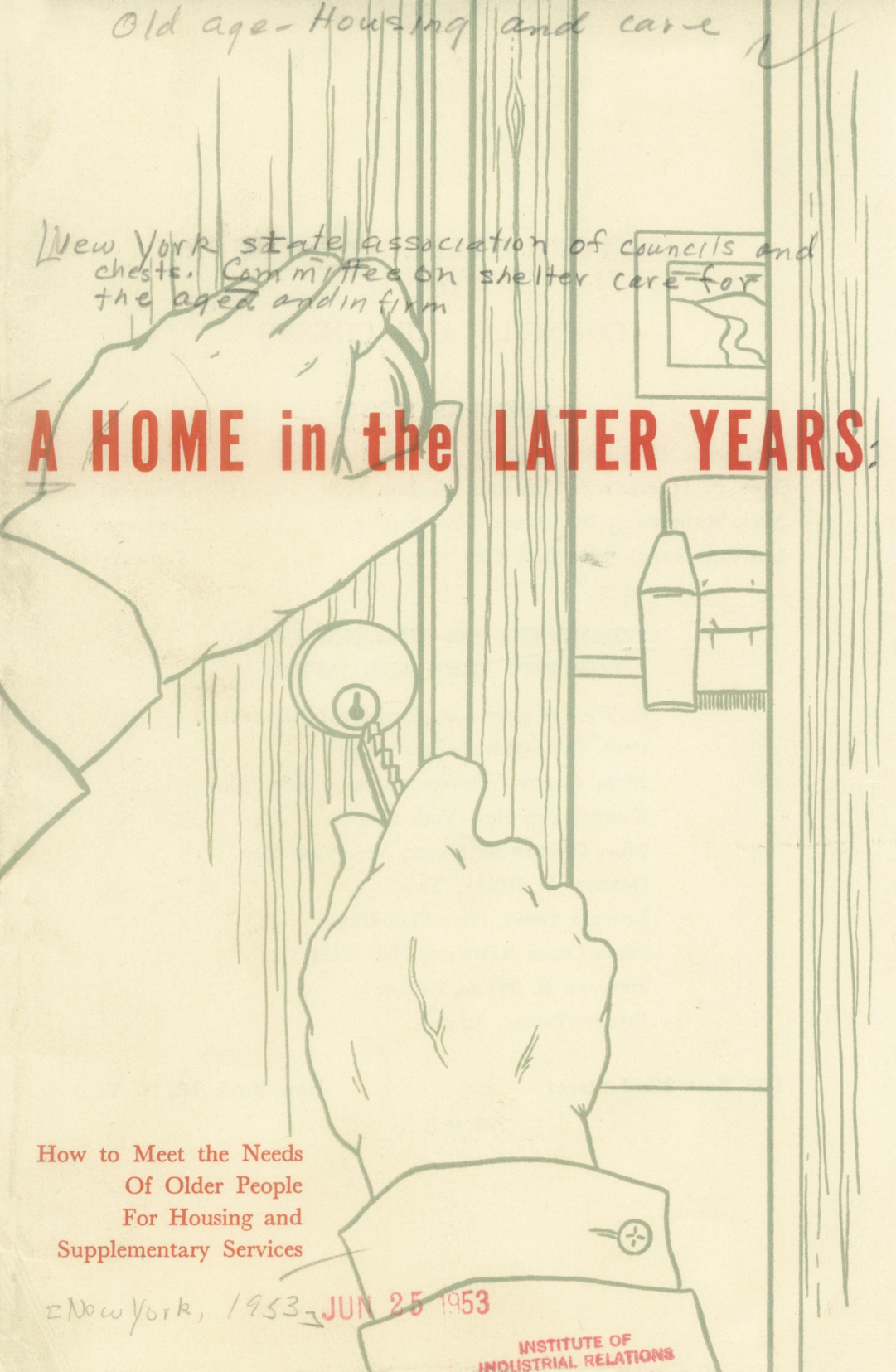
Old age - Housing and care

[New York state association of councils and chests. Committee on shelter care for the aged and infirm

A HOME in the LATER YEARS



How to Meet the Needs
Of Older People
For Housing and
Supplementary Services

NEW YORK STATE ASSOCIATION
OF
COUNCILS AND CHESTS

OFFICERS 1952-53

BENJAMIN E. SHOVE, Syracuse . . . . . *President*
MRS. A. HARTLEY ZIMMERMAN, Niagara Falls . . *Vice President*
MRS. RICHARD J. BERNHARD, New York City . . . . *Treasurer*
LOWELL IBERG, New York City . . . . . *Secretary*

COMMITTEE ON SHELTER CARE FOR THE AGED AND INFIRM

C. WALTER DRISCOLL, Syracuse, *Chairman*
PAUL BENJAMIN, Schenectady
MISS GLADYS FISHER, Albany (ex-officio)
KURT HERZ, New York City
MISS CATHERINE HIATT, New York City
GORDON F. HINES, Troy
LOWELL IBERG, New York City
MISS OLLIE RANDALL, New York City
HOWARD R. STUDD, Albany
PHILIP TAIETZ, Ithaca

105 East 22nd Street **New York 10, N. Y.**

1 9 5 3

FOREWORD

THIS BOOKLET has a clear and single purpose: to help community groups to bring about more adequate living conditions for older people. It is designed as both a guide and a stimulus to action. In both respects, it is a companion to "Community Action for the Aging," which the New York State Association of Councils and Chests published two years ago.

The Association is a widely representative, statewide organization. Thus it has been in a favorable position to draw upon much experience and talent in preparing this booklet. Some of the contributors are experts in shelter care of the elderly. Some are concerned with community planning and the coordination of community activities. Some are public officials; others represent private agencies. And the viewpoint of the layman has been combined with that of the professional.

The booklet seeks to appeal to a variety of readers, non-professionals as well as professionals, small groups as well as large, and private citizens as well as those in government posts.

The Association of Councils and Chests is grateful to the members of its Committee on Shelter Care for the Aged and Infirm, of which Mr. C. Walter Driscoll is chairman. This committee, whose membership is listed on the opposite page, was immediately responsible for planning and producing this booklet.

BENJAMIN E. SHOVE
President, 1952-53
Syracuse, N.Y., January 1953

A HOME IN THE LATER YEARS

Contents

Acknowledgment

This New York State Association of Councils and Chests gratefully acknowledges the services of the New York State Charities Aid Association which, as its secretariat, provided editorial and production assistance in the publishing of this booklet.

THE SCOPE OF THE PROBLEM

The housing needs of older people are long overdue for appraisal and action. They are only partially understood, if at all, in many communities. Shelter is still provided with the viewpoint of a bygone and simpler society, when those who reached advanced age were few in number and could, for the most part, live with younger relatives.

Today a different kind of need confronts the community. Private houses now are smaller. There is a stronger drive toward independence on the part of all persons. The tempo of change has enlarged the differences between consecutive generations. When the third generation rises, in a world of TV and atomic energy, there often is no meeting ground. A constantly increasing number of older men and women thus must seek places to live outside the home of a married son or daughter.

What are the needs of these older people in their search for the security of a home? They differ widely, just as the people themselves do.

Many persons are old only by the calendar. They are still strong, vigorous and potentially productive. But having reached sixty-five, they are likely to find that business and industry no longer have a place for them. Their retirement income is unequal to the standard of living they have enjoyed as wage earners, and they must make new living arrangements.

Another group may have passed beyond the stage of positive good health without actually becoming ill. They, too, must remain within a limited budget, and adjust to the further restrictions of declining physical and mental faculties. They can't climb stairs; they must avoid steep hills; they must be within easy walking distance of food supplies, physicians' offices, churches and recreational opportunities; they may object to the antics of boisterous youngsters, except when they seek the companionship of visiting grandchildren. Their houses or apartments should be designed so they can care for themselves, doing their own cooking and cleaning for as long as health permits.

Then there are people who cannot care for themselves completely. A housewife with arthritis, for instance, cannot do her own cleaning. Such individuals should not lose the privacy and independence that one's own home can give. An apartment building or a cottage colony with central food service and some household help can provide necessary aids without the limitations of group-care living. This arrange-

ment, too, may prove more economical than institutional care. In human dignity and happiness its worth is immeasurable.

Care in the Institution

Finally there are the older persons whose care can best be provided by a group-care agency; a boarding home, convalescent home, nursing home or home for the aged. Care in these institutions is for those elderly people who need the personal, medical or nursing supervision that they cannot obtain in their own homes. Group care, however, need not and should not ignore the balance between security and independence. This holds true for the private as well as the public institution, the proprietary as well as the non-profit. The resident should have as much freedom of movement and expression as possible. Adequate physical facilities, sound operating policies, and a staff that is skilled and sympathetic can round off the painful edges of regimentation.

The administrator of the institution, regardless of its type or size, should appreciate its role in the life of the community. He should recognize and take advantage of all services that are available in the community. He should, in turn, give the community the benefits of what the institution can offer it. Admissions should be carefully screened to make certain that the particular institution is, in fact, the best place for the applicant. In too many instances there have been indiscriminate placements in institutions. All community resources should be rallied to the aid of those admitted and those awating admission.

But an institution should not be considered a terminal facility, a last stop before the grave. On the contrary, it should continually seek to rehabilitate all those who have a potential for living more independently, and discharges should be made with full and friendly concern for the individual's readjustment to the community. Recreation and occupational therapy are among the essentials of an institution's program. Fruitful use may be made of volunteers, who can provide auxiliary services and help the residents to maintain maximum contact with the community. Experience proves, however, that volunteers are more effective when they have professional direction.

The community has responsibility for selective use of its institutions, regardless of type, and for helping them to become part of the total fabric of services for the elderly in the community. It must, in other words, use its institutions with full concern for the needs of all its older people.

In the following pages these various types of residence and care for older people are discussed in more detail. The discussion takes into account that local circumstances and conditions must shape the efforts of the community to help its older members, that a community cannot do everything at once, and that the various types of facilities and services, already existing and yet to be developed, are closely related to each other.

HOMES OF THEIR OWN

A home of one's own is a place where one may have the satisfaction of largely directing his own affairs. The older able-bodied person who must seek somewhat limited living accommodations will, if he is unusually fortunate, find a pleasant and adequate home of his own, a small house or an apartment. But such units are in very short supply. Too often the path leads only to the back street rooming house. Sagging iron beds and glaring ceiling lights produce a dreary atmosphere as well as physical discomfort. How many of the elderly are consequently driven to mental hospitals or nursing homes is a question for every community to ponder.

Small homes or apartments for older people should be planned for efficiency and convenience, and designed so that the elderly may occupy them as long as possible. Features of the ideal development should include:

1. Integration with larger units, so that the older person does not become segregated from other age groups.
2. Southern exposure, to make maximum use of sunlight.
3. Proximity to stores, physicians' offices, churches, recreational facilities, etc.
4. Elevator service.
5. Wide doorways, without sills, to permit use of wheel chairs.
6. Shelves and cabinets that are easy to reach.
7. Safety features, such as non-slip bathroom floors, hand rails on bathroom walls, wall light switches instead of pull chains, electric rather than gas ranges.
8. Heating arrangements to provide temperatures higher than those needed by younger people.

9. Community rooms to facilitate and encourage social contact.
10. Exits at ground level or at least requiring a minimum of steps; ramps may be employed instead of steps, and rails should be provided.
11. Porches which may be opened in warm weather and closed in cold weather without shutting out sunlight.

The development of small homes or apartments containing special features for the elderly has been undertaken in relatively few communities. Private capital thus far has virtually overlooked this investment opportunity, or at least has delayed action in deference to other pressures of the construction boom. There are, it is true, some examples of this type of development. For the most part they should be considered experimental, but information about them is available from the National Committee on the Aging of the National Social Welfare Assembly at 1790 Broadway, New York 19, New York. Information is also available from the Committee on the Hygiene of Housing of the American Public Health Association, at the same address.

A Start in Public Housing

Public housing authorities in this country are giving attention to the housing requirements of older people, but only a start has been made. The National Housing Act of 1950 (Title 2, Sec. 213) provides, under a cooperative plan, a major resource for financing such homes. The Housing Commissioner of New York State, by administrative order, has ruled that five per cent of all state-aided housing projects be reserved for older people. Special designs are prescribed, for which specifications may be obtained from the commissioner's office in Albany.

Federally aided housing projects are not so flexible in their accommodations. They are planned primarily for family living, and a single person may be admitted only if he is a former resident of a slum clearance site. A waiver is required from the federal agency for a single person to remain in residence as the survivor of a couple admitted as a family group.

Persons depending on Old Age Assistance or on comparable income from other sources have, of course, much the same needs as those with larger incomes. Their limited resources should be further recognized in public housing projects.

NON-INSTITUTIONAL CARE

Many older persons, from the standpoint of care required, are neither completely self-sufficient nor so dependent as to need residence in an institution. They should be helped to live in their own homes, which they may do if they have certain services, such as those of a visiting nurse, visiting housekeeper or social worker. Thus they may enjoy the independence and happiness of remaining among familiar surroundings. With proper planning their admission to an institution may be prevented or delayed. Institutional space is consequently saved for those who need group supervision.

The visiting housekeeper may assume that part of homemaking no longer within the elderly householder's competence. She may do the shopping, for instance, and cook one warm meal a day and do the cleaning and laundry. A visiting social caseworker may help the older person to adjust to living in the later years. She may also call upon other community services as needed. A visiting nurse may provide home nursing when ordered by a physician.

This kind of care is variously known as non-institutional care or as the non-resident plan. Experiments have been successfully conducted in Europe and, to a lesser extent, in the United States. Some leading institutions for the aging have initiated and supported the non-resident plan. They have appreciated the advantages to the institution as well as to the older person himself.

The key to non-institutional care is the bringing of all appropriate community services to bear upon the problems of those in need. Professional social services are provided as part of the regular program of an institution or through affiliation with existing social and health agencies. In effect, non-institutional care 1) extends care into the older person's own home, or 2) makes care available through outpatient or day care facilities in an institution or other agency. All of this is done in an individual approach, fashioned to meet the specific needs of the individual.

The resources of homes for the aged, hospitals, public health and public welfare departments, private family service organizations, and other agencies should be developed accordingly. The savings in full-time institutional care, which otherwise would have to be provided, may more than offset the cost of expanding these other resources.

Physical housing facilities for non-institutional care should be

developed, so far as possible, along the lines discussed in the previous section. Housing, in other words, should be designed to allow for the limitations resulting from the physical afflictions of age. But non-institutional care may, of course, benefit elders living in the homes of close relatives, or in foster family homes, as well as persons who live in homes of their own.

In a housing project having a substantial number of older people, a nurse might profitably be engaged as manager. She could make her skills available for emergencies and exercise sympathetic and knowing concern for the residents at all times. A nurse with a public health background would be particularly well-qualified for this task.

Non-institutional care may involve financial aid, from public or private sources, in supplement of the Old Age Assistance grant. The individual thus may continue his independent way of life and derive security from knowing that if he becomes unable to maintain his own home, despite the supplementary services, the institution will take care of him.

A recent and promising development in non-institutional care has been the placement of older people in foster family homes under the auspices of a family case-work agency. Many of the services involved are the same as those for the elderly who live in their own homes or with relatives. In a foster care program, however, the agency or an institution finds a family who will take care of an older person although not related to him. The foster family plan is still in an exploratory stage, and its progress is being carefully watched as an index to future action.

The whole concept of non-institutional care reflects up-to-date thinking. The plan is undergoing a good deal of scrutiny as to the kind of standards to be developed. Standards have not yet become so crystallized as those for institutional care, because experience is still relatively limited. There naturally are a number of questions concerning non-institutional care yet to be answered. For instance, should a small institution undertake its own non-institutional services if the community has a well-established family agency which can do an effective job as an agent of the institution concerned?

Regardless of such questions, the non-institutional concept recognizes that institutional care, while at times an essential and critically needed service, is still but one aspect of the community program. Homes for the aged, proprietary as well as non-profit, are an integral part of all the resources which *together* should cover the broad range of older people's needs.

INSTITUTIONAL CARE

The development of non-institutional care does not mean that institutional care is less important than in the past. As the needs of older people become better identified and as forward-looking programs develop, the institutions will be called upon to provide more and more specialized services. To do so they need guidance, support and encouragement from the community.

In a general sense, a home for the aged is any residence which houses a substantial number of older people who are receiving care as a group. In the more professional and legal sense, a "home for the aged" is only one type of shelter. The others include boarding homes, convalescent homes and nursing homes. Some are public institutions, financed by taxes and operated by the government. Others are private, operated either by an individual or a corporation. Some are non-profit, and others are proprietary. A preponderance of the residents is, of course, likely to be older people, but not necessarily so.

The distinctions between the kinds of homes are important because they reflect the extent and kind of care that is given. Furthermore, minimum requirements for facilities and service may be established by law for each of the different types. In New York State, for instance, the kinds of institutions are defined under rules of the State Board of Social Welfare. These definitions may be found an page 20.

The rules and regulations in New York State concern buildings, equipment, records, personnel and service. The rules define the types of institutions concerned and set forth requirements in broad dimensions. The rules for private homes for adults, for instance, provide that the residents "shall be humanely treated and suitably provided with whatever may be necessary for their nutritional needs, safety, comfort and well-being." The regulations evolve from the rules. They are more detailed and cover a wide range of subjects, including spacing of beds, providing of individual bedside tables and chairs, staff duties, records to be kept, fire hazards to be avoided, etc.

The complete rules and regulations of New York State for all types of institutions are too extensive for inclusion in this booklet, but those for nursing homes are listed on page 21, as a sample of the nature and scope of such requirements. Rules and regulations for other kinds of institutions may be obtained from the State Department of Social Welfare, 112 State Street, Albany, New York.

Inspection of Institutions

New York State laws provide for the inspection of private convalescent homes, private nursing homes, and private homes for adults. Representatives of the State Department of Social Welfare approve or disapprove private convalescent homes and private nursing homes in accordance with the rules of the Board and the regulations of the Department. The Department, under provisions of the Social Welfare Law, delegates to local welfare departments the authority for approving private homes for adults. In New York City, the City Department of Hospitals is charged with the responsibility for private proprietary nursing homes by the Charter of the city.

If a home is in complete conformity with the rules and regulations, it is approved for the care of residents; if it is in substantial conformity, it is provisionally approved pending compliance with the recommendations of the inspector. The inspector and the operator of the home usually agree upon a deadline date for compliance. If the changes are not made by then, either a time extension is granted or the home is disapproved for cause. In the latter case the operator of the home is notified that he may no longer accept residents for care. The local welfare commissioner is then requested to transfer any welfare residents to an approved home, where practicable, and to advise referring individuals and agencies to cease using the home for care until otherwise notified. Should the operator continue to accept residents for care, the State Board of Social Welfare may institute proceedings against him.

A recent revision in the Federal Social Security law places on the states increased responsibility for the medical care of older people in institutions. For some time the Federal government has partially reimbursed payments by the states for medical services rendered to eligible needy residents of institutions, private as well as public. The revision in the Federal law now provides that, effective July 1, 1953, Federal reimbursement for these purposes will be made only if the state has set up an authority or authorities which are responsible for establishing and maintaining standards for these institutions.

Laws concerning the care of older people, even though soundly conceived and properly administered, can establish requirements of only a minimum nature. They provide a floor below which no facility should be operated. Above the floor are many elements, tangible and intangible, that should enter into facilities and services for the aged. Legislation can protect the individual; it cannot assure his happiness.

A HAPPIER PLACE FOR ALL

Sometimes there may be a tendency to judge an institution almost solely on its physical facilities. Is the building architecturally attractive? Are the surroundings pleasant? Is there sufficient room? Is there plenty of light? Are the furnishings comfortable Is there enough equipment? Is it of the right kind? Is it all in working order? These questions, and others like them, are vital ones. Unless they are answered affirmatively, the institution is inadequate. But while physical facilities are important, they must not be viewed to the exclusion of the services provided.

Regardless of the type of institution, large or small, public or private, the well-being of the residents is also determined by these services. Life in an institution can be dull and devastating, if the elderly are treated as "charges" rather than as human beings. They must be thought of as individuals wishing to act and to live like other individuals. They need interests, friendship and activity. When these are provided, when the residents are given something to live for, the institution becomes a happier place for all.

The adequacy of physical facilities may be determined more easily than that of program. The plant layout and equipment are there to be seen; the scope and quality of services performed are less obvious. Nevertheless, certain principles and standards of administration and service apply to all group-care organizations. They have been carefully developed and are widely accepted.

A Check List for Assessing Program

Some of the more important principles and standards may serve as a check list in assessing group care for the aged, as follows:

1) Each group-care organization should be operated with full appreciation that it is a part of the totality of services available to older persons in the community, and that the community has a right to expect adequate service from an organization whether it is public or private and whether it operates for profit or not.

2) The organization should know the health, welfare, recreational and educational resources in the community and how to use these resources for the benefit of the people to be served.

3) Rehabilitation of all kinds should be a constant objective.

4) The admissions policy must recognize that institutional care, in the main, is most suitable only for persons who need protection from the problems of independent living. Each admission should be determined by the function of the particular institution, by what it is equipped to do, and by the need of the individual for such care. Will the home meet the applicant's own social and psychological requirements? Does the applicant himself recognize the limitations of institutional life? Competent professional judgment is usually necessary for a sound determination of an individual's suitability for admission. Recommendations by the physician, caseworker and other professional staff members may then guide final action by the administrator or the governing board.

5) The organization should make provision for medical and nursing care as needed. It should also ensure an adequate, wholesome diet suitable to the individual's needs.

6) The resident's privacy should be respected. For example, his mail should be opened only by him, and so far as possible he should have an opportunity to talk with his visitors in private.

7) The resident should have maximum freedom of movement inside and outside the institution and in the use of the institution's facilities, subject to reasonable rules and regulations.

8) The resident should have a personal choice, so far as possible, in the selection of clothing and should also have the privilege of providing or supplementing the basic furnishings and decorations of his room.

9) Spending money should be provided. The privilege of having one's own money to spend as one sees fit has strong psychological value.

10) Freedom of worship must be assured.

11) Policies regarding visitors and absences should be liberal. The resident should be encouraged not only to maintain ties with his close family, but also to participate in community activities so far as he is able.

12) Opportunities and facilities for social, educational and recreational activities should be made available through staff and volunteer services. The administration's awareness of modern psychological and social work thinking largely deter-

mines the extent of development to this end. Group congenialty is essential to the resident's happiness, as are leisure time activities.

13) Physical and occupational therapy should be made available as required.

14) Residents should have opportunities to participate in the management of the organization to the fullest appropriate extent.

15) They should also be encouraged to do useful work compatible with health and ability.

16) Counselling services should be provided for those in need of them, either by the institution itself or through other community resources. They should be made available to applicants for admission as well as to residents. They are particularly important in the initial stage of residency, when the individual is seeking to adjust to a new mode of living. Counsellors can assist the residents in their relations with other residents and with staff, and in working out various problems arising both inside and outside the home. Counselling is also important to the older person who may leave the home for residence elsewhere, by helping him to make the transition.

Current Research in Regard to Standards

Interest in the problems of older people is constantly increasing, and so is experience in ways and means of solving them. The resulting knowledge must, of course, be brought to the attention of persons concerned with care of the elderly, so that standards may improve. The National Committee on the Aging of the National Social Welfare Assembly has made a comprehensive study of standards for the group care of older people, and has incorporated its findings in a manual for administrators and boards of group care organizations as well as government, religious, fraternal, commercial and all other agencies and individuals that sponsor or supervise such care. The manual is in two volumes. The first is entitled "Standards of Care for Older People in Institutions — Suggested Standards for Homes for the Aged and Nursing Homes." The second (scheduled for publication in March 1953) is entitled "Standards of Care for Older People in Institutions — Methods of Establishing and Maintaining Standards in Homes for the Aged and Nursing Homes."

The Committee also has published an analysis of existing state regulations concerning standards in the various states. The document is entitled "A Preliminary Report on State Regulatory Programs for Licensing and/or Standard-Setting for the Sheltered Care of Older People." It also has published "A Selected Bibliography Related to Sheltered Care of Older People," which has been used as a basis for choosing the reference materials listed on page 27 of this booklet.

Information and publications developed by the committee may be obtained from its headquarters at 1790 Broadway, New York 19, N. Y.

THE INSTITUTION AND THE COMMUNITY

A community has the right to expect adequate services from its organizations, and the organizations have the right to expect support and guidance from the community.

It is the community's responsibility, for instance, to provide a channel whereby all its institutions serving older people may coordinate their efforts with other services and adapt their policies and functions to local needs. A council of social agencies or other central planning gruop may serve this purpose. It may bring to the attention of other agencies and the public at large, the needs of older people. It may serve as both catalyst and medium for bringing together all community resources in their behalf. Institutions for the aging, like other group-care organizations, should be represented on the boards and committees of the central groups and smaller organizations should not be ignored in this respect.

At the same time the institution should be willing to accept the responsibility of participation in central planning for community betterment. The policy makers, administrator and staff should also work in cooperation with other agencies toward bringing the community into the institution. They should make use of volunteer visitors to provide many auxiliary services that help older people find new interests and engage in wholesome activities.

Under professional supervision, the volunteers may work with the residents, individually or in groups, to assist in the development of hobbies and other interests. Through adult education techniques, volunteers may help the residents to continue growing mentally in

spite of declining physical vigor. Fields for volunteer efforts include handicrafts, reading, music, dramatics and many others. The volunteers may become friendly companions to the residents and help them combat feelings of isolation and uselessness. The elderly who are ambulatory may be transported to picnics and concerts, club meetings, church activities, the movies, and other sources of activity and entertainment. Here the volunteer plays a very direct and important part in enabling the older people to join in community affairs.

In another respect, too, volunteers may be a strong asset to the institution. The visitors may give objective advice to the administrator and staff on improving conditions in the home, whether the home is private or public, non-profit or proprietary. There has been, in the past, more organized visiting to public and private non-profit homes than to the proprietary homes. The latter, however, should not be neglected. Visitors also may become an important link with the outside community in explaining to other agencies and to the public at large what the institution is doing and what it requires to do a better job.

All in all, volunteer visitors may bring much happiness to older people in institutions, and, incidentally, may themselves enjoy the personal satisfaction to be found in these worthwhile endeavors.

ACTION BY THE COMMUNITY

What can the community do — what can you do — to strengthen residence facilities and services for the older population? The answer already has been given, to a substantial extent, in the foregoing discussion. In summary, you may work to:

1) encourage public and private housing interests to build modest units, designed and located to meet the special needs of the elderly;

2) expand visiting nurse, housekeeper, social and other services to make more non-institutional care available to older people in their own homes, and stimulate group care organizations to provide services for those who may live in their own homes but come to the institution for these services;

3) ensure the adequacy of facilities and services for residents of homes for the aged and other group-care agencies.

Now, it may be asked, how do you do all this? Community action generally takes place through the successive stages of 1) organization, 2) fact-finding, 3) planning the program, and 4) carrying it out. The development of these stages is outlined in "Community Action for the Aging," published by the New York State Association of Councils and Chests and available at 20 cents a copy from the Association's hadquarters at 105 East 22nd Street, New York 10, N. Y. With regard to the residential requirements of older people, you might bear in mind the following considerations:

1) Organization — If your community has a Council of Social Agencies or other central planning agency, you have a ready-made vehicle for setting up a Committee on the Aging. Many Councils of course already have groups working on the problems of older people. If your community has no central planning agency and no existing group concerned with the aging, you may organize a Committee on the Aging, but it must be widely representative of the community. You must be sure, for instance, that on the committee are represented the group-care agencies, which too often in the past have not been included in the various steps of organizing and putting into effect programs for the benefit of older people.

2) Fact-finding — The Committee on the Aging must find out what exists and what resources are available in regard to the residential requirements of the older population of the community. What, exactly, does the community already have in apartments, small homes, boarding homes, convalescent homes, nursing homes, public institutions, etc.? What does it cost the residents to live in them? What are the government regulations concerning institutions for the aging, and how are they enforced? What is the true quality of care being provided in these institutions? The answers to these and other questions should come, in part at least, through visits to the institutions themselves. Other important sources are the Council of Social Agencies or other central planning group and its constituent members, public and voluntary; the Departments of Public Welfare and Health; the Chamber of Commerce; labor and business organizations; the public housing authority, planning commission, and other government agencies.

3) Planning the program — The process of fact-finding never completely ceases, but you now have enough facts in hand to start planning what to do. Here you will need the advice of many interested individuals and groups, not excluding the

elderly themselves. You may get valuable advice from the very people and organizations who have given you the data in your fact-finding efforts. You will want to consider how you can increase the number of housing units suitable for older people of restricted means; how you can help the group-care organizations to improve their services; how you can encourage social agencies to develop programs of non-institutional care; whether you should sponsor training institutes for professionals and volunteers in this field. In the planning stage you should establish priorities for action, in accordance with the local situation.

4) Carrying out the program — You will reach your objective by making the maximum practical use of what the community has to offer. While you should act vigorously and resolutely, you should also guard against trying to do everything at once. You will find that group-care organizations, business, labor, government agencies and others will help if they are properly approached.

A Few Final Words

Through all stages of action by the community, you will want to recognize that an elderly person should have the benefits of independence to the fullest feasible extent. But many older people are denied privacy, freedom of choice, and the opportunity to continue producing up to their capabilities. Community action — and that means action supported by the total community — may fill their need for more suitable and satisfying living conditions.The time for action is now.

DEFINITIONS OF TYPES OF INSTITUTIONS

(based on rules of the New York State Board of Social Welfare)

BOARDING HOMES are usually privately sponsored, and in New York State are legally known as *homes for adults.* A private, proprietary home for adults is one operated for the purpose of providing therein, for compensation and profit, to three or more aged, infirm, or disabled persons, lodging, board and such personal services other than medical, nursing or bedside care or hygienic attention, as are or may be necessary to protect and assure the health, safety and comfort of such persons. A private, non-profit home for adults is one operated by a membership or religious corporation for the same purpose.

CONVALESCENT HOMES are usually privately sponsored. A private, proprietary convalescent home is one operated for the purpose of providing therein lodging, board and bedside care or hygienic attention, but not including medical or nursing care, to sick, invalid, infirm, disabled or convalescent persons, for compensation or profit. A private, non-profit convalescent home is one operated by a membership or religious corporation for the same purpose.

NURSING HOMES are usually privately sponsored. A private proprietary nursing home is one operated for the purpose of providing therein lodging, board and nursing care to sick, invalid, infirm, disabled or convalescent persons, for compensation and profit. A private non-profit nursing home is one operated by a membership or religious corporation for the same purpose.

HOMES FOR THE AGED are either publicly or privately sponsored. Most of them are operated by county or other public welfare departments, or by religious or membership corporations. Homes for the aged generally are the larger institutions which provide medical or at least nursing services. Some of them contain what is defined as a *public home infirmary.* This is a medical care facility operated by a public welfare district as a separate unit of a public home for the aged and providing continuing medical treatment and nursing care in addition to board and lodging to patients admitted on the written recommendation of a physician.

RULES OF THE NEW YORK STATE BOARD OF SOCIAL WELFARE

ARTICLE 17-B

PRIVATE NURSING HOMES, PROPRIETARY OR NON PROFIT — ASSISTANCE AND CARE

1. *Definition*
   a. A private proprietary nursing home shall mean a facility operated for the purpose of providing ladging, board and nursing care to sick, invalid, infirm, disabled or convalescent persons, for compensation and profit.
   b. A private non profit nursing home shall mean a facility operated by a membership corporation or a religious corporation for the purpose of providing lodging, board and nursing care to sick, invalid, infirm, disabled or convalescent persons.
2. *Medical care*

   A patient receiving care in a private nursing home proprietary or non profit shall remain under continuing medical care and supervision which shall have been arranged for by the patient or those responsible for his care prior to his admission.
3. *Nursing care*

   The nursing service in each private nursing home proprietary or non profit shall be under the direction of a registered professional nurse or a liscensed practical nurse. There shall be a sufficient number of nurses and attendants to provide adequately for the care of the patients, including night coverage.
4. *General care*

   In each private nursing home proprietary or non profit, patients shall be humanely treated and suitably provided with whatever may be necessary for their nutritional needs, safety, comfort and well-being.
5. *Dietary*
   a. In each private nursing home proprietary or non-profit; diet shall be balanced and varied and shall conform to modern standards of adequate nutrition in relation to the patients' requirements.
   b. Provision shall be made for the preparation of therapeutic diets under the supervision of a qualified dietitian, qualified nurse, or a physician.
6. *Facilities in each private nursing home proprietary or non profit shall include*
   a. Standard equipment for the care and comfort of patients.
   b. Isolation rooms as needed.
   c. Facilities separate and apart from those for adults if children under sixteen years of age are accepted for care.

7. *Compliance with laws, ordinances, rules and regulations*

Each private nursing home proprietary or non profit shall comply with:

a. Any law or ordinance affecting the health of the inhabitants of the county, city, town or village in which such nursing home is located.

b. Any applicable rule or regulation of the local board of health, or of the State Sanitary Code.

c. Any law or ordinance regulating the erection of the buildings of such nursing home.

d. Any law or ordinance, or regulation made pursuant thereto, enacted to protect the patients thereof from fire, or requiring the erection of fire escapes or additional means of egress.

e. Any applicable rule or order of the State Board of Social Welfare and any regulation of the State Department of Social Welfare.

f. Any other law, ordinance, rule or regulation applicable to such nursing home.

8. *Protection from fire and unsanitary conditions*

The patients of all such private nursing homes proprietary or non profit shall be cared for in buildings:

a. Provided with adequate fire protection.

b. Kept in a sanitary condition.

9. *Records*

a. Each such private nursing home proprietary or non profit shall keep records as follows:

(1) An individual medical record of each patient.

(2) A register of admissions and discharges.

(3) Proper books of accounts. (This section applies only to those private nursing homes proprietary or non profit in receipt of public funds.)

(4) Copies of daily menus.

b. Such books and all records of the transactions of the nusing home or concerning the patients thereof shall be open for the inspection of members, officers and other representatives of the State Board of Social Welfare.

10. *Reports*

Each private nursing home proprietary or non profit shall prepare and file with the Department, at its office in Albany, such information as to population, services provided and operations in such form and for such periods as the Department may prescribe. In addition, such homes which are in recept of public funds shall provide such financial information as the Department may require.

REGULATIONS OF NEW YORK STATE DEPARTMENT OF SOCIAL WELFARE

ARTICLE 13

PRIVATE NURSING HOMES, PROPRIETARY OR NON PROFIT

1. *Medical and nursing services*
   a. One registered professional nurse or licensed practical nurse shall be in charge of the nursing service and as many nurses and attendants shall be retained as required for the number and condition of the residents. At least one nurse or attendant shall be provided for each eight to fifteen chronically ill residents depending on the amount of care necessary.
   b. A physician shall be called when residents are in extremis and shall pronounce death.
2. *Nursing home facilities shall include:*
   a. Accommodations separate and apart from those for adults, if children under sixteen years of age are accepted for care.
   b. Beds spaced at least three feet apart.
   c. Adequately ventilated and lighted bedrooms above ground level.
   d. Suitable and adequate toilet and bathing facilities.
   e. Adequate living and dining rooms for ambulatory patients.
   f. Isolation rooms with separate toilet facilities as needed to care for patients with infectious conditions, mental disturbances, or terminal illnesses.
   g. Provision for clothes closets or individual lockers.
   h. Facilities for sterilizing or disinfecting bedside articles to prevent transmission of infection, a locked wall cupboard for solutions, a cupboard for treatment equipment, ventilated space to store 24-hour urine specimen bottles and a nurses' work table.
3. *Nursing home equipment shall include:*
   a. Hospital beds, as needed, which can be raised at the head and the feet, equipped with side boards.
   b. Individual bedside tables containing standard individual toilet equipment.
   c. Signal bells at each bed; electric outlets installed near each bed for reading lamps, heating pads, etc.; commodes with arms; foot stools; wheel chairs; stretchers; comfortable arm chairs.
   d. Nursing equipment including treatment trays, clinical thermometers, hot water bags or electric pads, ice caps, medicine glasses, bed trays, rubber sheeting, rubber gloves, measuring cups, drinking tubes, sputum boxes, paper disposal bags, paper tissues, screens for privacy, and a sterilizer for small instruments.
   e. A locked cabinet for medicines and drugs.

4. *Principles observed in the care of the sick shall include the following:*
   a. Placement of public charge patients in a private nursing home only on the basis of the diagnosis and written statement of a licensed physician that such care is necessary.
   b. Transfer to a hospital or sanitarium of patients suffering with mental illness, active tuberculosis, other communicable disease or any condition requiring hospital care.
   c. The use of restraint only on physician's order and recording of the restraint used.
   d. Prohibition of locking patients in their bedrooms by day or night.
   e. The return to the physicians who prescribed them of unused portions of individual narcotic prescriptions.
   f. Immediate examination and appropriate treatment by a physician of patients who have had accidents and a recording in the physician's progress notes of such injuries and treatments.
5. *The head nurse's responsibilities shall include the following:*
   a. Planning the program of care of patients to be performed daily by each member of the nursing staff.
   b. Daily observation of each patient and recording of pertinent observations.
   c. Making rounds with physicians and calling them when necessary.
   d. Supervision of the work of nurses and attendants.
   e. Supervision of the administration of medicines and treatments, and keeping an inventory of medicines, drugs, and medical equipment.
   f. Supervision of the diets of patients and notifying the dietitian or superintendent when special diets are required.
6. *The duties of the nursing staff shall include the following:*
   a. Personal care of invalids:
      (1) Sponge or tub baths, shampoos, manicures, and pedicures, mouth wash and dental hygiene as needed.
      (2) Assistance with morning toilet and combing of hair.
      (3) Assistance with use of commode or bedpan and keeping the utensils clean.
      (4) Assistance with getting invalids in and out of bed, with walking and with dressing.
      (5) Giving medicines and treatments as outlined by the head nurse.
      (6) Giving special care daily to the backs of patients to prevent decubitus.
      (7) Weighing patients at regular intervals and keeping record of weights.
   b. Serving meals and nourishments:
      (1) Carrying trays to patients and feeding those unable to help themselves.
      (2) Serving between-meal nourishments when necessary.

(3) Collecting, washing and replacing drinking glasses.

(4) Noting and reporting changes in partients' appetites and their remarks about meals.

c. Supervision of rooms and equipment.

(1) Airing of mattresses, pillows and rubber sheets periodically.

(2) Checking linen needs of individuals in regard to towels, washcloths, personal linens, etc., and keeping sufficient soap and toilet paper available.

(3) Dusting the furniture daily and cleaning the rooms.

(4) Making of beds, and changing of linen at least once a week and as often as necessary.

(5) Cleaning, disinfecting and keeping in order all equipment used for nursing treatments.

7. *Medical, nursing and other records shall include:*

a. Abstract of care and treatment given in other institutions.

b. Physician's diagnoses, orders, and progress notes.

c. Nurses' notes and graphic charts where indicated.

d. Control records of narcotics and sedatives including statement of individual dosage.

e. Death certificate stubs or copies of death certificates.

f. Record of accidents and fires.

g. Register of admissions and discharges containing name, address, age, date and source of admission, date and place to which discharged, sex, religion, marital status of each patient, and name and address of nearest relative or friend.

h. Any other information required by the State Department of Social Welfare.

8. *Religious care*

The comforts of religious ministration shall be made available to all patients in nursing homes.

9. *Fire protection*

a. Non-ambulant or helpless patients shall not be placed on any floor above the second unless the building is of modern fireproof construction.

b. Employees shall be instructed and trained in the use of fire fighting equipment and in the means of rapidly evacuating the building by frequent drills.

c. There shall be an adequate water supply for fire fighting purposes.

d. There shall be suitably marked alternate exits from each occupied floor.

e. In combustible structures over two stories high, suitable outside iron stairways must be provided pursuant to Section 334 of the New York State Public Health Law.

f. A sufficient number of appropriate fire extinguishers of approved types shall be available.

g. Each home shall have telephone service.

h. A gong or other device loud enough to be heard in all parts of the building shall be readily available for use in case of fire.

i. Smoke barriers (self-closing doors) shall be provided between floors to limit the spread of fire. All openings to laundry chutes and dumbwaiters shall be provided with self-closing doors.

j. All fire hazards including the following shall be eliminated:

(1) Gas or oil heaters unless directly connected with a flue.

(2) The use of kerosene for cooking or lighting.

(3) Rubber tubing used as connections for gas burners.

(4) The accumulation of combustible material in attics, basements, or other parts of the home.

(5) Non-metal containers for ashes.

(6) Improper storage of paints, varnishes, oils, etc.

(7) Electrical wiring installations which do not comply with the National Electrical Code and standards of the National Board of Fire Underwriters.

(8) Obstructions to corridors and exits.

10. *Accident prevention*

a. Every reasonable and essential means of avoiding accidents shall be provided.

b. Adequate protective devices and practices shall be assured.

c. Immediate investigation of the cause of accidents shall be instituted and corrective measures adopted.

d. Periodic inspection shall be made of all physical facilities, equipment and machinery to determine whether hazards exist and if maintenance is safe.

REFERENCE MATERIALS

Listed below are selected reference materials prepared by governmental or voluntary agencies and individuals. Many of them have been chosen from a bibliography prepared by and available from the National Committee on the Aging, 1790 Broadway, New York 19, New York.

A TWENTIETH CENTURY PHILOSOPHY FOR HOMES FOR THE AGED — Ollie A. Randall. Paper published in proceedings of the New York State Conference on Social Work, Buffalo, 1949. Limited number of mimeographed copies available from the National Committee on the Aging, National Social Welfare Assembly, 1790 Broadway, New York 19, N. Y.

Statement of some of the effects of Twentieth Century economic and social changes upon the home for the aged, the needs of the older individual, and the services the home renders to its residents and to those in the community who seek admission to the home.

CARE OF CHRONICALLY ILL OLDER PERSONS, Three Articles — by Dr. Joseph H. Kinnaman. Limited number available from Dr. Kinnaman, Nassau County Department of Health, 1053 Franklin Avenue, Garden City, N. Y.

PLANNING FOR THE CHRONICALLY ILL — A COOPERATIVE TASK — Published in New York State Journal of Medicine, Vol. 49, No. 5, March 1, 1949.

Discusses some of the practical problems and the methods used by one public agency in regulating sheltered care for the chronically ill.

STANDARDS IN NURSING HOMES, talk given at New York State Welfare Conference, 1952, and planned for publication in American Journal of Public Health.

A psychological approach to standard setting with primary concern for maintaining good mental health.

THE NURSING HOME — A MEDICAL CARE FACILITY — Published in American Journal of Public Health, Vol. 39, No. 9, September, 1949.

Examines needs of chronically ill persons unable to remain at home but not requiring hospitalization. Describes methods of supervision used by the licensing agency in one county in helping to increase quantity and improve quality of services for this group.

COMMUNITY ACTION FOR THE AGING, New York State Association of Councils and Chests, 105 East 22nd Street, New York 10, N. Y., 1950. 20¢.

Designed to help volunteer and professional groups develop local programs for the aged. Sets forth practical and specific steps in organization and procedure.

COORDINATING CARE OF THE AGED — A Social Planning Bulletin, No. 5. Council of Jewish Federations and Welfare Funds, 165 West 46th Street, New York 19, N. Y. 35¢.

Basic principles and objectives of community planning, with emphasis on individualization of services. Includes a consideration of sheltered care and its coordination with other services for the aged.

DEFINING BOARDING HOMES AND BOARDERS, VERSUS NURSING HOMES AND PATIENTS, State of New Jersey Department of Institutions and Agencies, Trenton 7, N. J.

Provides clarification of terms and facilities.

DIRECTORY OF INSTITUTIONS FOR ADULTS IN NEW YORK STATE, State Department of Social Welfare, 112 State Street, Albany, New York. 65¢.

EPISCOPAL CHURCH HOMES FOR THE AGED — II, SELECTION OF RESIDENTS, The National Council, Protestant Episcopal Church, 281 Fourth Avenue, New York, N. Y. 1948.

Describes how older people feel at the time of applying for admission to a home, and procedures which can aid in reaching the most constructive decision. Points up the value of trained professional workers.

LUTHERAN SERVICES FOR OLDER PEOPLE — Henriette Lund. National Lutheran Council, Division of Welfare, 50 Madison Avenue, New York 10, N. Y., 1951. $1.00.

Standards and goals developed by one national agency as a guide to its affiliated local organizations operating homes for the aged, including recommendations for professionalized service at intake and in social services to residents.

NURSING, BOARDING, CONVALESCENT AND REST HOMES FOR THE AGED, INFIRM OR CHRONICALLY ILL, PRELIMINARY SURVEY, Wisconsin State Board of Health, Division of Hospitals and Nursing Homes, State Office Building, Madison 2, Wisconsin.

Questionnaire directed to operators of such homes as a guide for planning and as a tool in community education in a newly established state program of standards. Contains detailed coverage of buildings, grounds, equipment, number of residents, types of illness serviced, professional services and facilities, food service, staff, and charges.

NUTRITION GUIDES:

EATING IS FUN FOR OLDER PEOPLE TOO, — The American Dietetic Association, 620 N. Michigan Avenue, Chicago 11, Illinois. 50¢.

Designed to help managers of small homes and proprietary nursing homes in planning healthful, attractive meals for older people.

FOODS FOR HEALTH AS WE GROW OLDER, Nutrition Service, Community Service Society, 105 East 22nd Street, New York City. 25¢.

Recent findings concerning healthful eating in later years. Includes food requirements and sample menus.

FOOD GUIDE FOR OLDER FOLKS, Home and Garden Bulletin #17, Bureau of Human Nutrition and Home Economics, U. S. Department of Agriculture, 5¢.

Gives food needs of older people and suggests ways to meet special nutritional problems.

PROPOSED MINIMUM STANDARDS — Rules and Regulations for the Licensing of Nursing Homes by the Illinois Department of Public Health, Springfield, Ill. 1951.

Statement of proposed standards; includes newer concepts of the care of individuals, and statements of both minimum and desirable standards. Also contains detailed descriptions of general procedures, services to the individual, and resident accommodations, including building requirements and interior details.

REGULATIONS GOVERNING THE ESTABLISHMENT AND MAINTENANCE OF PRIVATE PROPRIETARY NURSING HOMES, CONVALESCENT HOMES AND HOMES FOR THE AGED OR FOR CHRONIC PATIENTS, City of New York Department of Hospitals, 125 Worth Street, New York, N. Y. 1949.

Contains an introduction discussing desirable standards, as well as a presentation of minimum standards. Reports use of Consultation and Information Service by the Department of Hospitals to discuss with applicants for establishment of such institutions their purpose and plans prior to the purchase or lease of property or other investment of funds, so that an understanding of the building, sanitation, personnel and other requirements for operation may afford a basis for an estimate of the investment needed and the probable operating costs.

REPORT, RECOMMENDATIONS AND DIRECTORY of the Division of Welfare Agencies, Board of Pensions, Presbyterian Church in the United States of America for the Year 1950, Witherspoon Building, Philadelphia 7, Pa. 1951.

One section of this report, "Care for the Aged," describes both resident and non-resident care and outlines basic policies to be considered by boards of Presbyterian homes in planning service.

RULES OF THE NEW YORK STATE BOARD OF SOCIAL WELFARE AND REGULATIONS OF THE NEW YORK STATE DEPARTMENT OF SOCIAL WELFARE, 112 State Street, Albany, New York.

Rules and regulations concerning institutions for the aging.

STANDARDS FOR CARE OF OLDER PEOPLE IN INSTITUTIONS. National Committee on the Aging of the National Social Welfare Assembly, 1790 Broadway, New York 19, New York. 1953. Volume I and Volume II.

This is a manual. The first volume sets forth suggested standards for homes for the aged and nursing homes, and the second volume (due in March 1953) discusses methods of establishing and maintaining standards in such institutions.

SUGGESTED STANDARDS FOR HOMES FOR THE AGED — The Welfare and Health Council of New York City, 44 East 23rd Street, New York, N. Y. 1948. 50¢.

Suggested standards for establishment or remodeling of a home for the aged, based on the experience of representatives of 86 homes and others active in work with older people. Covers planning and construction of building, living accommodations, furnishings, personnel, nutrition, recreation, rules and regulations, entrance requirements, and fees. Useful appendix calls attention to the value of "Extension Care" (home care) as part of an institutional program.

25 cents a copy

426