



Alzheimer's Awareness Family Night

LEADER'S GUIDE

SESSION #7:

Making the Residential Care Decision Work

Basic Guidelines for Hosting a Family Night

Educating the loved ones of those with Alzheimer's disease can help improve not only their caregiving experience, but the quality of life of those with the disease. To this end, we have created a series of family night sessions designed to assist you in addressing major topic areas related to Alzheimer's disease.

Family nights have two goals:

1. To provide practical information for families and friends of those living with Alzheimer's disease.
2. To help reduce the stress associated with having a loved one with Alzheimer's disease by offering that information in a friendly and supportive atmosphere.

To facilitate the first goal, this packet contains both information for you as the session leader and ready-made handouts for attendees. The second goal may be achieved in a variety of ways, for example:

- Make **invitations** to the family night warm, enticing, and clear, and provide directions and any important details.
- When a potential attendee **responds** to the invitation, be sure the person who answers the phone has a smile in her voice and is well-informed about the event.
- Provide an **atmosphere** that delights the senses. The setting for your meetings should look and smell pleasant, be an appropriate temperature, and offer comfortable seating. Tasty refreshments should also be available for attendees.
- **Welcome** each attendee as he or she arrives. If you have invited other staff, residents or volunteers to help you, make sure they are trained to do the same. Provide easy-to-read **name tags** for everyone.
- **Learn** as much as you can about each attendee's situation *before* the program begins by chatting with them when they arrive, rather than spending that time making last-minute notes or other preparations.
- **Introduce** attendees to one another so that each person feels a part of the group.
- Do your best to **present information with ease and confidence**. Remember that your audience **WANTS** you to succeed. They want to learn new information and come away with tips for being better caregivers, and they will be grateful that you are genuinely interested in their individual needs and experiences.
- Encourage **participation** from attendees by acknowledging their responses and answering additional questions with a positive demeanor.
- **Follow up** by inviting them back to future sessions. Provide them with handouts even if they miss a session. Get back to them with any questions you could not answer initially.
- **Seek attendees' input** about the session, as well as how to improve future sessions.

Room arrangement

If possible, arrange the room in a circle or semi-circular rows so that people can see each other. This automatically adds an element of friendliness. If there are rows, keep them wide. Because many older adults need to get up and move around regularly to prevent stiffness, make sure they feel free to do so – or build breaks and/or stretches into your session.

Using the materials effectively

- Make sure you have enough pens or pencils and that you have made enough copies of handouts for each attendee before everyone arrives.
- When attendees arrive, we suggest you give them only *Handout #1: Opening Exercise* and a pen or pencil. Each session begins with a puzzle, exercise or conversation starter related to the evening's topic that is intended to arouse their curiosity, along with the questions we expect to answer during the session. These activities will always be labeled as "Handout #1: Opening Exercise."
- Once attendees have completed *Handout #1*, and you have offered a brief explanation of its relevance, give each participant a copy of *Handout #2: No-Pressure Quiz*. Remember to keep the introduction of the opening quiz light and humorous. The quiz is not intended to measure attendees' knowledge as much as it is designed to be a vehicle for a discussion of the evening's important topics.
- Wait until the end of the session to pass out *Handout #3: Important Points and Resources*, but let attendees know at the beginning of the session that you will be providing an additional handout before they leave. We want to promote discussion and draw out the experiences and knowledge of the attendees. If they are given the discussion points at the outset, they are less likely to give original thought to the questions, and it is their comments that are most likely to enliven the session.

Using the leader's guide

- Material intended for the session leader only is provided in Arial type.
- Material to be presented to attendees (such as questions to ask or directions to be given) is provided in Times New Roman type.
- Each leader's guide provides a fair amount of detail about session topics. If your time is limited, you may wish to consider incorporating less of this detail.

General instructions for each session

- Begin the session by welcoming the group and introducing yourself and any assistants you have asked to help.
- Try to avoid discussing “housekeeping” issues during the session. Instead, provide information, such as the location of restrooms, on a flip chart so that even late-comers will be informed.
- Posting a session agenda is also recommended and should include any planned breaks. If you are not planning a session break, direct attendees’ attention to the restroom flip chart, and encourage them to ‘get up and go’ anytime. Doing so lends a touch of humor while letting attendees know you realize they are adults who can make their own choices about comfort.
- One of the principles on which this material is based is that those in your audience are the best teachers. Throughout each session, we offer questions to ask attendees. Their answers are likely to vastly enrich each session, provide many concrete examples related to various subtopics, and spark interesting and relevant conversations. Offering attendees a chance to respond to questions, and *then* filling in whatever details they don’t mention is an excellent way to keep attendees involved.
- Practice going through the materials before you begin, not only to become familiar with them but to have a sense of how much time each section will take. Assign a time period – depending upon the total amount of time you have – for each section, and be sure to allot enough time for attendee input and questions related to each section. Do your best to adhere to your planned schedule so you don’t feel rushed. You may opt to offer to stay after the session to discuss the experiences of anyone who didn’t have the opportunity to share during the session.
- Make the material your own. Add your own stories, insights, and creativity as time and topics allow.
- Begin and end on time. This is always appreciated – even by late-comers.
- At the end of the session, create a simple parting ritual: Let attendees know when the group will meet again and what topics will be addressed. Invite them to stay for more refreshments and to visit with each other and with you. Thank them sincerely for their shared insights and their devoted efforts as caregivers.

Training techniques to keep in mind

Dealing with the “gotta-have-an-answer” question

As you lead family nights, you are likely to encounter an attendee who has come to your session for the express purpose of finding an answer to a specific question about a particular situation. Once he has asked the question, there are essentially two ways to answer:

- If the question is relevant to the topic being discussed, give a time limit, which you announce (“This is a complex issue, but we can devote the next three minutes to an answer.”). You may wish to ask for more detail about the situation (What interventions has he tried? What were the results?) When you feel you have the needed detail, ask for input from other members of the audience – they may have terrific ideas. If there is still time, provide any answers of your own as well as you are able.
- If the question is *not* relevant, or if your allotted time has run out, write the question on a post-it note and put it in a “parking lot” –a flip chart, white board, or wall that is reserved for unanswered questions. Tell the person you can’t answer his question now, but that you will be happy to address it either at the end of the session if time allows or after the session.

When you don’t know the answer

When you don’t know the answer to an attendee’s question it’s best to say so, but promise you’ll do your best to find out and follow-up. Once you have found an answer, report back to the person who asked by phone, email or in writing. If it’s important to multiple people, provide the answer to the whole group in your next session.

When one person dominates the session

Often, people don’t realize they are monopolizing a group discussion, but as the session leader, you have a responsibility to remedy the situation. Depending on your personal style, you may choose to be straightforward or subtle in your approach. You can say something direct, such as, “I appreciate your input, Mrs. Jones, *and* now I would like to hear from other members of the group.” (Using “and” instead of “but” validates Mrs. Jones’s input while sending the message that others deserve a turn to speak as well.) A more subtle approach might be to toss a Koosh ball, Nerf ball, or beach ball, and establish that only the person holding the ball can speak. That tends to liven up a session with color and motion, and keeps the discussion spread out. Whatever approach you choose, do your best to encourage active participation among all attendees without allowing one person to control the conversation.

When someone doesn’t participate at all

In any group there is likely to be someone who chooses to simply listen. Respect that choice. If a ball is tossed to him (such as in the approach above), make sure he understands he can pass it to someone else without commenting. At the same time, after the session or during a break, make a point of talking with him to find out if he is finding the session useful or if he has any specific questions. He will appreciate not being put on the spot in front of everyone and will probably give you honest feedback. Often, those who choose to listen are perfectly content, but just don’t wish to speak in front of a group.

Opening Exercise and No-Pressure Quiz

As attendees arrive, give each person a copy of Handout #1, and ask them to figure out what phrase the drawing represents. When everyone has arrived, and after welcoming them all, ask them for their answers.

The phrase the drawing represents is “They’re on your side.” It’s intended as a reminder that when your loved one moves into a residential care community, you gain a whole new team of advocates. Sometimes it may not seem that way, however, so tonight we’re going to be talking about some of the issues related to moving your loved one to a residential care community and how you and your loved one can make a smooth adjustment to these new circumstances.

Because tonight’s focus is a little different from most of our previous Family Nights, tonight’s no-pressure quiz is only half as long as most of the previous ones have been – just 5 questions. It’s called a “no-pressure quiz” because it’s just that. It won’t be graded, and no one will see your answers but you. And, as always, those of you with real test anxiety can choose to leave your quiz paper blank for now, and just fill in the correct answers as we go!

Most people have mixed emotions when their loved one moves into a residential care community. This session is aimed at addressing those emotions, easing the transition, and helping family caregivers to begin to move forward with their own lives.

Once attendees have finished completing their no-pressure quizzes, use the quiz questions to facilitate discussion. The answers to each question are highlighted. (You will notice that each question is followed by related discussion topics in this leader’s guide.)

Facing the Diagnosis

Ask participants for their answer to the first question.

Question #1

Family members who place a loved one in a residential care setting are almost always experiencing grief, even if they don’t realize it. Which of the following is NOT something they are likely to be grieving about?

- a. The loss of their loved one’s independence
- b. The loss of the relationship they once had with one another
- c. The changes in the person’s lifestyle that automatically come with residential living
- d. Their inability to continue caring for the person at home
- e. The curtailment of sleepless nights**

The answer to this is probably obvious to all, but the question is meant to introduce the discussion that follows. Many people do not think of themselves as grieving or in mourning, but we would not be human if we were unaffected by the many losses and changes that accompany a loved one being diagnosed with Alzheimer's disease.

Usually, when people are given a diagnosis of Alzheimer's disease, they feel devastated. There are exceptions, however. Sometimes they experience an odd kind of relief to finally be able to put a name to their confusion. Some people with Alzheimer's disease who had been worried for years about their memory loss, for example, are comforted by the knowledge that the forgetfulness is not their fault

While some may feel a sense of relief, Alzheimer's disease is still a terminal illness of increasing disability that lasts an average of about 10 years after diagnosis. Because of the progressive nature and debilitating effects of the disease, family members of people with an AD diagnosis usually begin mourning immediately for the lost future plans, and the loss of a sense of control.

- The person with AD frequently is saddened by the knowledge that after decades of being, for example, a breadwinner, a protector, a loving father, and a helper in time of need, he will no longer be able to carry out those roles.
- Those with AD are also saddened by the knowledge that they will eventually lose most of their abilities, and that they have no control over those losses.
- The well spouse or adult child of a person with AD is often reluctant to take over responsibilities that have given the person meaning. Loved ones may also experience stress from adding these new responsibilities to an already full schedule.
- The spouse of a person with AD frequently mourns the loss of the relationship with his constant companion and sexual partner.
- The adult child may mourn the loss of the reliable support and comfort the parent has always provided.
- Perhaps most of all, family caregivers frequently yearn for the person their loved one *used* to be and the life they once had.

Give attendees a chance to respond with any other feelings they may have had at the time their loved one was diagnosed. It is not unusual for people to go through some of the classic signs of mourning when a loved one receives a diagnosis – denial, anger, grief, and bargaining before acceptance – and attendees' comments may reflect this.

In time, however, the shock of the diagnosis wears off, and families find ways to adapt and learn to live well with each other.

Ann Davidson is the author of two books: *Alzheimer's: A Love Story: One year in My Husband's Journey* (© 1997) and *A Curious Kind of Widow: Loving a man with Advanced Alzheimer's* (© 2006). Her husband Julian was a research scientist at Stanford University when he was diagnosed with Alzheimer's disease at age 59. He died 12 years later, in

2001. Mrs. Davidson also wrote an article for the quarterly journal *Alzheimer's Care Today*, (October – December 2007, pages 294-300) in which she talked about her experiences.

She wrote that her marriage wasn't perfect and that she didn't adjust easily to Julian's losses. He had particular problems with getting lost on his way to familiar places and with language. He said things like, "Where's the stuff . . . the big stuff . . . not your big stuff . . . my other stuff . . . the one that's different?" When Ann didn't know how to answer, Julian became angry and frustrated. She had a vision of both of them "going down," he babbling and wandering, she helpless and alone. She suddenly realized that if they were going down, she wanted it to be in a spirit of love, not in fear and anger, and that was her transforming moment. She began to learn to actually LIVE with Alzheimer's disease, rather than just attempt to survive it.

Ann Davidson is careful to explain that what "worked" for her as a caregiver would not necessarily be right for other caregivers, but you may find her words make sense to you.

Give attendees a chance to talk about their own successes in living with Alzheimer's disease. What have been the shining or transforming moments for them?

Facing a Move to Residential Care

Ask attendees for their answer to question #2.

Question #2

Now that Alzheimer's disease has become well-known, family caregivers are usually good at seeking out help when they need it.

- a. True
- b. False**

Unfortunately, the answer is still false and likely to be for many years to come.

Eventually, Julian's needs became too great for Mrs. Davidson to handle on her own. Mrs. Davidson wrote: "Only in hindsight did I realize that at various turning points I waited too long to seek help. I thought I could (and should) do things myself. My life might have been easier had I known to ask for, and find, appropriate help sooner."

Ask attendees if they have learned the same lesson, and if some would like to share examples.

Most people whose loved one has Alzheimer's disease make the choice of moving that person to a residential care community with great reluctance, and Mrs. Davidson was no exception. Even when family caregivers have seriously damaged their own health by caring for a person with AD – and recent studies show that the responsibilities of caregiving can shorten a person's life by several years – they still almost invariably feel they should

have been able to provide care on their own. The fact that in a residential care community their loved one has *multiple* staff to perform the tasks they were attempting alone doesn't seem to matter. Making a decision to move a loved one to a residential care setting is frequently seen as an admission of personal failure by family caregivers.

Therefore, spouses and family members frequently face move-in day with a bittersweet mixture of guilt and relief. The guilt often comes from being unable to be superhuman, as well as recognition of the loss of privacy and freedom that a loved one inevitably experiences in a residential care setting. The relief comes from knowing the care responsibilities are now shared.

If attendees have a loved one in a residential care community now, ask if they are willing to share some of the feelings they experienced on move-in day.

There is always an adjustment period when someone moves to a residential care community. Sometimes this period can be difficult, but sometimes there are also unexpected joys. Ann Davidson wrote, "To my great surprise, Julian thrived in the residential care center. They took him off the heavy drugs he had been prescribed. He grew less anxious in the simple, structured environment. He could barely talk, but he became more alert, affectionate, and cheery, usually greeting me with smiles. Now that the grind of daily caregiving was over, I had more energy to be Julian's friend."

Ask attendees if they experienced any pleasant surprises in the process of moving a loved one into a residential care community.

Adjusting to New Challenges

Ask attendees for their answers to question #3.

Question #3

"Trigger issues" are problems that lead to catastrophic outbursts by people with Alzheimer's disease.

- a. True
- b. False**

The answer we're looking for is B – false. There may be certain "trigger" events that reliably upset individuals with AD, but we are using the term here in reference to family caregivers with loved ones in residential care communities.

For many family caregivers there is always some level of unease even, after their loved one has made a good adjustment to his new living quarters. The question, "Have I done the right thing?" raises its guilty head every time their loved one's hearing aid is misplaced or her new outfit comes back faded from the laundry.

These are “trigger issues” – seemingly modest problems that mask deeper concerns and prompt disproportionate reactions from families. For instance, if your mother’s new outfit comes back from the laundry faded, the issue is probably not *really* one ruined outfit. Rather, since laundry seems like a fairly simple task, you might wonder, “If staff can’t get the simple stuff right, how can I have confidence that they are getting the tough stuff right? How can I be certain my mother is getting quality care?” Laundry becomes symbolic of your loss of control over your mother’s care and your need to trust strangers to keep her from harm.

When these mishaps happen – and they will – try to examine your feelings. A ruined outfit *is* a problem, and we hope that the community where this happened will offer a solution to satisfy you; however, if you are unusually upset, perhaps it’s because:

- You *are* afraid that laundry issues are indicative of problems with larger care issues.
- You have had a bad day or week and are feeling like you’re at the end of your rope. Do you need someone to solve the problem *and* offer some words of comfort to you?
- You have been getting grief from other relatives and friends about your decision.

Let’s look at these issues in more detail, one at a time.

If you’re concerned that laundry problems are indicative of a larger competency issue, share your concerns with the nursing director or administrator. Be specific about what you’ve observed and what you think needs to be changed. For example, if you’ve observed an aide being rude to a resident, you may worry that she will treat your loved one the same way when you are not around. Rudeness is not acceptable. If you’ve observed a lack of activities or inappropriate activities, that’s important to mention, too. Confidence in a community isn’t built because there are no problems. It’s built because problems raised are taken care of to your satisfaction.

Ask attendees if they can give an example of a time when a problem was well-solved and increased their loyalty to a company. It does not have to be an example from residential care. Note that you are looking for examples of problems solved, not ones that turned out disastrously, because that could drag down the rest of the session.

The second trigger issue was when you are at the end of your rope. If you need a hug or a listening ear on a bad day, you would be amazed how happily most staff will comply. The more staff and families get to know each other on a personal level, the better their ongoing relationship will be. The ultimate goal for staff and family members is to become a team.

The final trigger issue deals with the grief other family members or friends may give someone who chooses to place a loved one in a residential care community. We’ll talk more about family dynamics using question #4.

Families Are a Varied Lot

Ask participants for their response to question #4.

Question #4

Family members tend to have many different viewpoints because they have diverse experiences with the person with AD. Therefore, in family disagreements, the majority should rule.

- a. True
- b. False**

This is a can of worms, but the intention of this discussion is to help family caregivers recognize that their voice – especially when they are the primary caregiver – carries a heavier weight.

Sometimes a sibling, child, or other close relative who has *not* been responsible for the direct care of a loved one with AD may question your decision to move that loved one to a residential care community. It's important to remember that those who have not had to provide personal care 24/7 for a person with AD often have little idea how exhausting and challenging it can be.

Now let's talk for a minute about those family members and how when a person is diagnosed with Alzheimer's disease, families rarely speak as one voice.

- Spouses often cover up for their partners to keep from being a burden to their children.
- Family members who live far away may over-estimate or under-estimate their loved one's disability.
- An adult child may not be ready to face the deterioration of a beloved parent and, to buy time, denies there is a problem.
- The sister of the person with AD may lay guilt on her overburdened sister-in-law about her brother's care. ("You can't move him to a facility. You promised him you would take care of him at home!")

Today's families are often complex and may include multiple marriages, stepchildren, ex-sons or ex-daughters-in-law, adopted grandchildren, or gay or lesbian partners. Each of them may harbor unique agendas, jealousies, and fears. If you are the primary caregiver, don't let lesser involved relatives sap your energy or cloud your judgment.

Ask attendees to share ways they curtailed or dealt with bad advice from relatives.

The Good Times

Ask participants for their answers to question #5.

Question #5

While it is likely that there will still be problems to solve when a person moves to a residential care community, there are also likely to be many benefits. Which of these is not usually one of them?

- a. The resident is likely to benefit from the activities and socialization.
- b. The resident is likely to benefit from a calmer and more structured environment.
- c. The resident is likely to experience a reversal of his memory loss.**
- d. The family caregiver is likely to be able to enjoy more relaxing visits with his/her loved one.
- e. The family caregiver is likely to be able to resume some of the pleasurable pastimes that were neglected when he/she was a full-time caregiver

We expect this answer will be obvious, but again it is an introduction to this last topic.

The answer is C. Now let's talk about some good things about residential care environments. Mrs. Davidson said that she was surprised by how quickly her husband adjusted to his assisted living community. As it turned out, he *needed* the calm, slow-paced, structured environment he found there. Although he rarely spoke, he was recognized and valued, and that made him more alert and interested.

It is not surprising when people adjust well to the lowered stress and gentle pace of an Alzheimer's specific residential care community, but in Julian Davidson's case, moving to the community also was beneficial in two other ways:

- First, he was taken off the heavy-duty medicines he had been prescribed, and which Mrs. Davidson hadn't questioned. As we mentioned in an earlier session, many people with AD have been given drugs to treat "problem" behaviors, when the behavior was actually caused by something concrete, such as pain.
- Second, Julian was removed from a somewhat overstimulating (and, therefore highly stressful) environment. Mrs. Davidson had invited her daughter's family to come live with them, because she hoped her daughter could provide extra help. But the extra five people – their daughter, her husband and three young children – overwhelmed Julian. He said things like, "Too much! Too big!" and shouted at the children, even hit them. The situation had to change.

In the assisted living community, Julian was freed from the chaos and accepted as he was. One of the handicaps families work under is the fact that they have known the person with AD for decades – in the case of adult children, all their lives. They know the person their loved one *used* to be and may still try to relate to the person in the ways they always have. Staff members, however, have no sense of who the person once was; they simply accept him as he is.

Because staff accept people as they are, they often see things differently than family members. For example, once Julian had spent a weekend at a "respite camp" where he

had attached himself to the camp director. He followed her around constantly for two days, in Mrs. Davidson's words, "jabbering gibberish into her ear." But at the end of camp, he was awarded a certificate for being "the most poetic and spirited camper." The camp director saw Julian's boundless energy as "spiritedness" and his creative gibberish as "poetry."

Julian's situation was different from that of many people with AD, who, rather than being surrounded by too many people, become isolated and under-stimulated at home. Their days pass with so little interaction that their disabilities tend to increase. Socialization and gentle stimulation are other benefits of residential care.

Mrs. Davidson indicated that there were also benefits for her. She said that not having daily care responsibilities enabled her to be Julian's *friend* when she visited. One of her favorite pastimes was to take him on outings to a nearby lake where they walked and sang. (She sang; he hummed.) Knowing he was safe and well-cared for also brought her peace of mind.

As evidenced by Ann Davidson's experience, residential care can provide many benefits for both the caregiver and the care recipient.

If some of your attendees have their care recipients in a day center or residential care setting, ask for their ideas about the benefits.

Family Members Can Help Staff

When staff are being trained to care for someone with Alzheimer's disease, one of the first things they will hear is, "know the person." In today's long-term care world, "person-centered care" is a phrase often used. It means care that is individualized for each person rather than scheduled according to staff convenience. If Mr. Jones likes to sleep in, rise slowly, and eat breakfast in his pajamas, person-centered care dictates that he should be accommodated. If Mrs. Smith is a night owl who likes to play a game of Scrabble about midnight, ideally, her desire will be met, too. While some residential care communities are better able at providing person-centered care than others, staff should be trained that knowing the preferences, routines, interests and life story of each resident is essential.

When a person has Alzheimer's disease, they aren't always able to provide all this information, but *you* can. You can provide immeasurable help by sharing your loved one's quirks and habits with care staff. Additionally, following a set routine – at least a set sequence of events – is often important to the person with AD. If you know that your mother was never comfortable getting out of bed until she had put her glasses on, or that she never ate breakfast unless she had first washed her hands and face, that's key information. Perhaps the reason your mother is resisting getting up at the residential care community is that no one knows to make sure she has her glasses on before they try to help her out of bed. If your mother isn't settling down to sleep easily, perhaps it's because she has had a lifelong habit of eating a bowl of Cheerios before bed, and the staff doesn't know about this important routine.

When a person moves to a residential care community, he or his family caregiver is usually asked to complete a survey of his favorite foods, TV programs, and hobbies, among other things. That information is helpful. If a staff member knows that your father loves the New York Yankees, for example, the Yankees can be a topic of conversation while she is helping him dress or bathe. If a staff member knows that your husband has bad memories from the Korean War, she can be sure he doesn't watch the violence on the evening news. Let staff know if he loves a morning walk, but hates group exercise classes. They will more likely make sure he isn't compelled to attend the "Sit and Be Fit" class.

There are a million things you know about your loved one that staff doesn't, and most of those things won't show up on any survey. Your knowledge will come out slowly over time. We hope that staff will turn to you for advice on how you managed things they are having trouble with, such as bathing, when you were the primary caregiver. If they don't, you can volunteer your tricks of the trade, and they will usually be grateful. Staff who don't know you well may be afraid to admit they are having a problem.

Give attendees an opportunity to talk about any of their own experiences where a small detail made a difference in their loved one's care. (These can pertain to residential or day care.)

In her book, *Getting to Know the Life Stories of Older Adults: Activities for Building Relationships* (© 2007, Health Professions Press) Kathy Laenhue has an exercise in which she asks caregivers to circle all of a list of 75 positive characteristics that apply to the person they are caring for. It is a reminder that people with Alzheimer's disease can still be kind, generous, fun-loving, reliable, and exhibit any of dozens of other positive qualities. Think of the best qualities of your loved one. Share those with staff, too. If they know that your mother has always been a diplomatic, tolerant, problem-solver, perhaps they will find ways to draw out those wonderful qualities in your mother. If your husband has always been cheerful, friendly, and a great jokester, perhaps they can find a role for him as greeter to newcomers.

Ask attendees to take a moment to think of their loved ones' best qualities. What are they? (Many times family members are so focused on the "holes" in their loved one that they fail to realize the many positive qualities he has retained in spite of his Alzheimer's disease.)

Often when a person moves to a residential care community, his family caregiver is initially at a loss over how to fill the time she suddenly has on her hands. Sometimes people just need to catch up on sleep for awhile. Other times, they like to continue some aspect of their caregiving role. If you are one of those people, tell the staff what you would like to do. A man who comes in daily to lovingly feed lunch to his wife provides nourishment for her body *and* her spirit, and he is helping his own spirit, too. Do what's best for you.

Closing

In our last session next week, we are going to talk about how to have good visits with your loved one in a residential care community. We'll also offer some hints about how to interact well with your loved one, whether he is living in a residential care community, or still living at home.

As you end the session, give attendees their last handout. Consider closing with this story:

Because we always like to close on a light note, we thought we'd share this story from a mother who regularly brought along her 4-year old daughter when she delivered meals to homebound older people. Her daughter was always intrigued by the appliances of old age, particularly the canes, walkers and wheelchairs. One day the woman found her daughter staring at a pair of false teeth soaking in a glass. She braced herself to answer her daughter's likely questions, but her daughter merely turned and whispered, "The tooth fairy will never believe this!"

Never cease to look at the world with wonder!