Often, when I make rounds in the nursing home, my patients are off the floor at “activities” that seem better suited to a cruise ship than a health care facility. Worse, unit staff are also unavailable, busy transporting residents to these events. I am told that a full activities schedule is a measure of a good nursing home, but to realize this, it’s hard to understand how going to a birthday party or sing-along makes the home much better, particularly since many of my patients are too confused to understand or participate. Wouldn’t staff time be better used in direct patient care?

Dr. Jeff responds: In 1963, Dr. Sidney Katz and colleagues in Cleveland created a functional scale called the Index of Independence in Activities of Daily Living (ADLs). The five activities deemed necessary for independent living were bathing, dressing, transferring out of a bed or chair, eating, and the various tasks known in health care parlance as “toileting.” In 1983, the “instrumental activities of daily living” (IADLs) were added, which include skills such as using a telephone, preparing meals or doing housework, shopping, managing money, and taking prescribed medications properly.

Still, these abilities describe a remarkably limited existence if nursing home residents were to be given nothing more. Clearly, nursing home residents live somewhat constricted daily lives, since they are in an institutional setting due to inability to perform several ADLs and IADLs independently.

The daily schedule for a nursing home resident consists of “a.m. care”: toileting, transferring, dressing, and grooming – followed by three meals with perhaps and evening snack; and “p.m. care”: reversal of the morning process, culminating with being assisted back into bed. The day might be punctuated by medication rounds, dressing changes, and a few diaper changes or visits to the bathroom. Even in a well-run nursing home, where residents’ choices regarding times of rising and sleep are honored and a few meal choices are available, this boring routine continues day after day.

Anyone who has taken an airplane flight long enough to provide meals knows that, however skimpy they have become, they provide diversion during an essentially boring and unpleasant experience. Nursing home resident councils similarly tend to focus on the food – no matter how good or unsatisfactory it may be – because it is the only interesting thing that occurs many days.

Just as airlines added movies and then television to help flyers pass the time, nursing homes transitioned from simply lining up all the residents in the hallway to seating them in front of television sets to watch dysfunctional families acting out their aggressions on daytime television. Even when severely cognitively impaired residents cannot follow the events on the screen, it is rare that a television is ever turned off. Most depressing of all can be the occasional sight of a resident staring at a blank television screen.

**Attack of the Killer Bs**

Of course, the bleak picture I have painted is not the whole story in most homes. But certainly, a lack of activities that might enhance self-worth contributes to subclinical and clinical depression among nursing home residents. Interestingly, dementia patients tend to fill their time with the reasonable notion that they are supposed to be doing something. This, in turn, produces wandering, attempts to “elope” from the facility, or agitation related to a feeling that they are in the wrong place or failing to meet their dimly remembered responsibilities.

A meaningful activities program fights the boredom. Many facilities with specialized dementia units directly involve certified nursing assistants and other unit staff in floor activities that take place all day long. These might include a CNA with a pleasant voice leading songs or a group preparing a snack (everyone knows that food you prepare yourself always tastes better), or even a beauty experience where residents have their hair combed, make-up and lipstick applied, etc. I know of one highly successful program in which a program director involved her residents in all the events leading up to and through her daughter’s wedding. Residents reviewed bridal magazines and discussed preferred dresses and veils, discussed and deliberated on the menu, and watched the wedding video repeatedly for days.

Many years ago, I participated in an interview with a candidate for the activities director who proposed to take our facility “beyond the three Bs” of activities. As we stared, he explained that the three Bs were Birthdays, Bible, and Bingo. These, indeed, have been mainstays at many facilities. Although all three can be fulfilling to seniors, only a small sliver of the population would find their lives fulfilled by the Bs alone. Instead, many activities are moving toward a paradigm of therapeutic recreation.

**Therapy That’s Fun**

Therapeutic recreation is designed to help patients preserve their independence and perhaps restore motor, social, and cognitive functioning. Certified recreation therapy specialists get bachelor’s level training and complete an internship prior to certification. Regimens are based on individual residents’ interests and physical or cognitive deficits. Some elements might include small- and large-group activities, which promote socialization and offer opportunities for shared discussion. But because many residents find group activities overstimulating or even threatening, alternatives might be individualized reading, crafts, or refreshers on life tasks.

Therapeutic recreation can be an ideal aspect of the postacute-care setting, as it encourages a poorly or marginally motivated patient to perform activities based on individual interests and goals. For long-stay residents, it is an obvious component of the person-centered approach. The Minimum Data Set 3.0 assessment tool incorporates questions about a patient’s prior activities. The skilled professional can help the team move from that historical information to a care plan appropriate for the individual’s current status and needs.

Music plays a vital role in human existence. From lullabies to dirges, music is an accompaniment to significant and everyday life events. Carols, hymns, and the national anthem all provide context and meaning.

Music has been part of our patients’ lives. Many grew up in an era when the radio was readily available and the phonograph or Victrola was common. Music was available on jukeboxes in diners and bars and in the background at restaurants, stores, and elevators. By the 1950s, radios were readily available in most automobiles and portable radios could be taken to the beach. Eventually came LPs, tape decks, CDs, and generations of computer chip- and internet-based devices. Musical memories reside in areas of the brain distant from those of language and are often preserved when more verbal components of memory have been deserted. I have seen elderly patients with advanced dementia and no verbal skills sing along with the “Star Spangled Banner.”

Of course, meaningful music for one person might prove boring or unpleasant to another. Large-group musical activities tend to provide popular favorites, whereas individual tastes are varied and idiosyncratic. One jazz concert per year at a facility (which for most would be a stretch) would certainly not satisfy a jazz lover, particularly as a Mingus enthusiast might not be satisfied with Duke Ellington. With a little effort and modern technology, it should be possible to provide most residents with music individualized to their personal tastes, whether opera, Beach Boys, salsa, or country. There is abundant evidence that music – with its ability to “soothe the savage breast,” as poets know – can be an effective means to calm agitated dementia patients. The electronic age also allows many new opportunities to individualize activities to residents. Options include electronic books for people cognitively intact but lacking physical ability to hold a book and turn the pages, and a wide variety of Wii or other video game systems that promote exercise, balance, and cognitive function at levels appropriate to the individual.

Most of the activities that I currently propose in my facilities can and should be done within living units. This allows more time for the activity, an increased sense of living in a “neighborhood,” and less demand on staff time and energy to provide transportation.

From a physician’s point of view, the nursing home might be seen first and foremost as a medical facility. From a resident’s, the home is just that and the activities you question are the very “stuff of life.” Even for short-term residents, whose days may be busy with therapy, activities may be a bridge to the life they hope to resume.

Your concern does raise the issue of scheduling. Whenever possible, unit staff should be informed when to expect your rounds and which patients you are expecting to see. Those residents should in turn be notified that they have a doctor’s appointment and be given the approximate time to expect you. Then your interactions with these people are more efficient, and the medical examination can be part of their activities schedule for the day.

**You Know What They Say About Idle Hands**

By Jeffrey Nichols, MD

Dear Dr. Jeff,

I often wonder what they say about idle hands. Sometimes it seems as though we have so much to do that it’s hard to understand how going to a birthday party or sing-along makes the home much better, particularly since many of my patients are too confused to understand or participate. Wouldn’t staff time be better used in direct patient care?

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By Jeffrey Nichols, MD

You can also comment on this and other columns at www.caringfortheages.com, under “Views.”